Lanarkshire ALCOHOL & DRUG Action team

Problems perceived by recovering drug users

An essential part of needs assessment

Lanarkshire Alcohol and Drug Action Team

Methadone Client Needs Assessment Survey Report

A survey carried out on behalf of the Lanarkshire Alcohol & Drug Action Team

Mark C Connelly

July 2003

Contacts for further information:

Mark C Connelly
Information & Research Officer
Lanarkshire Alcohol & Drug Action Team
Lanarkshire NHS Board
14 Beckford Street
Hamilton
ML3 0TA

t: 01698 206 342
f: 01698 206 390
e: mark.connelly@lanhb.scot.nhs.uk
www: nhslanarkshire.co.uk/adat

Acknowledgements

Thanks to Rosie Kidd of Lanarkshire Drug Service, and Kevin Watters, David Shields and Jim Robertson of the Community Addiction Teams for co-ordinating the administration of the surveys.

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Background

According to recent prevalence estimates there are over 5000 opiate and/or benzodiazepine users in the Lanarkshire ADAT area (Hay, McKeganey and Hutchinson, 2001). Heroin in particular has been the cause of most problems for the majority of people entering treatment for drug problems in the past few years (ISD, 2003).

Methadone is the main treatment drug for opiate dependence used in Scotland (EIU, 2002a). It is estimated that there are currently around 1500 methadone clients in Lanarkshire. Due to the rapid expansion of methadone treatment it was recognised locally that clients may not always have been receiving the holistic, person-centred service required to maximize the benefits from methadone treatment and facilitate social inclusion. These issues were raised at a local ADAT planning event attended by a wide variety of stakeholders, including service users and family members/carers, and have also been indicated in previous research on social inclusion of recovering problem drug users.

Aim

As part of a wider needs assessment, the aim of this study was to investigate the needs of longer-term methadone clients in relation to a range of problem areas.

Methods

A cross-sectional survey was conducted in various methadone clinics throughout Lanarkshire in Autumn 2002. The participants comprised a convenience sample of 131 clients who had been attending methadone clinics for a period of more than six months. The survey tool was distributed as a self-completion questionnaire by clinic nurses and then returned in a sealed envelope to a box at the clinic reception. Alternatively the survey could be administered as a structured interview where deemed appropriate.

A total of 131 clients responded to the survey - 96 males (73%) and 35 females (27%). It is estimated that this represents around 35-40% of all current long-term methadone clients in Lanarkshire. Respondents ranged in age from 18 to 52 years, and the mean age was 30 years.

Results

Accommodation, living arrangements & relationships

The accommodation status of respondents living in households was considerably different from that of other Lanarkshire residents. Most respondents lived in non-private rented accommodation, around a quarter either owned or privately rented their house, and a relatively small number were either homeless (n=9) or living in supported accommodation (n=2). None of the respondents described themselves as 'roofless' i.e. sleeping on the streets. Forty-five (35%) respondents indicated that their accommodation was a problem. When asked how much help they needed, most responded that they need a high amount (17%) or some (14%) help.

Most respondents either lived with their parents (31%), their partner (22%) or alone (20%). Twenty-six (20%) indicated that their living arrangements were a problem. When asked to describe their problems, the main issue raised was overcrowding (n=11). The majority of respondents described themselves as either single (55%) or living with their partner. Only 11 (8%) indicated that they had significant relationship problems.

Alcohol & Drugs

Sixty-nine (54%) responding clients said that they had not drunk any alcohol in the last week. Of those who drank alcohol in the last week, the number of units consumed ranged from 2 to 300, and the mean number of units was 39. Compared to the 1996 Lanarkshire Health and Lifestyle Survey[1] (LHLS), the distribution of the current sample across the various 'drinking zones' was significantly different. Fourteen respondents (11%) indicated that their alcohol use was a problem. The majority of those reporting alcohol problems said they need some (n=7) or a high amount (n=5) of help.

Sixty-four respondents (49%) reported using illicit drugs in the week prior to the survey. Sole use of cannabis and heroin were the most frequently cited types of drug use. In terms of polydrug use, a total of 19 respondents indicated combining 2 or more of heroin, cannabis and benzodiazepines. Very few respondents indicated use of cocaine or crack. Eleven respondents who reported using heroin and/or benzodiazepines were also in the warning or danger zones for alcohol use. Nine respondents (7%) indicated having injected drugs in the previous week, and three of these reported having shared injecting equipment. Thirty-two (24%) respondents indicated that their use of drugs besides methadone and alcohol was a problem. The majority of those reporting drug problems said they need some (n=14) or a high amount (n=13) of help.

Health

Fifty-two (40%) responding clients stated that they had at least one physical health problem. This compares to a figure of around 30% of respondents in the 1996 LHLS between the ages of 16 and 54 who said they had a long-standing illness, disability or infirmity. Asthma, hepatitis and damaged limbs were the most commonly cited types of physical problems. Of the 50 individuals who indicated how much help they needed with their physical health problems, most said they needed some (n=27) or a high (n=11) amount of help. 82% of respondents reported spending any time using council or private leisure facilities. This compares to around 50% of age-matched respondents in the 1996 LHLS.

Fifty-four (41%) respondents indicated that they had problems with their teeth or mouth. Rotting teeth was the most commonly cited type of dental health problem. While comparable information for the general population in Lanarkshire is not available, an indicator of dental health problems in the LHLS (1996) is the proportion of people had less than 20 teeth. The proportion for the 16-54 age range was 26%. Of the 47 respondents who indicated how much help they needed with this problem, most said they needed some (n=27) or a high (n=13) amount of help.

Forty-three (33%) respondents indicated that they had mental health problems - proportionately more females (46%) than males (28%). Depression was the most frequently cited problem, followed by paranoia and anxiety. In terms of the general population in Lanarkshire, 60% of respondents in the 1996 LHLS indicated medium or high stress levels and 34% indicated medium or high depression levels. Most respondents in the current study indicated that they needed some (n=25) or a high (n=14) amount of help. Respondents who indicated mental health problems were more likely to have indicated that they had problems with illicit drug use, and to have reported use of benzodiazepines or cannabis in the last week.

[1] Lanarkshire Health Board (1996).

Education/training

Fifty-nine (45%) respondents indicated that they had no formal qualifications - this compares to around 38% of LHB residents (GROS, 2003). Around half indicated that they were educated to O-grade/standard grade level (n=35) or had attained qualifications through further education (n=31). Three respondents had Highers/A-level equivalents and one individual had a degree (compares to 14% LHB residents). Thirty-eight (29%) responding clients indicated that their education/training qualifications were a problem. Over 90% of those indicating that they had problems required some (n=20) or a high (n=12) amount of help.

Economic/financial situation

The majority (67.2%) of respondents described themselves as unemployed – a far higher rate than among the general population in Lanarkshire. Income support and incapacity benefit were also being claimed by a far higher proportion of methadone clients than other LHB residents. Thirty-three (25%) respondents indicated that their employment situation was a problem for them. Of the 31 respondents who indicated how much help they needed with this problem, 16 said they needed some help and 15 said they need a high amount of help.

Sixty-five (50%) respondents indicated that they had debt problems. A significant relationship with reported alcohol use in the previous week was found such that respondents who indicated debt problems were under-represented in the 'none' category, and progressively over-represented in the 'sensible', 'warning' and 'dangerous' zones. Those reporting debt problems were also significantly more likely to have reported that they had alcohol problems.

Legal situation

Ninety-eight responding clients (75%) reported that they had criminal convictions, and 45 (34%) had court cases pending. However, only 17 (13%) of respondents reported that their legal situation was a problem. Females were significantly less likely than males to have criminal convictions.

A relationship with reported alcohol consumption in the last week was also found such that males who had drunk more than the maximum recommended weekly amount of alcohol in the previous week were significantly more likely to have court cases pending than those who did not. Considering both male and females respondents together, those who reported having injected drugs in the previous week were also more likely to have court cases pending.

Treatment status

The length of time in treatment ranged from 1 – 121 months, and the average was 27 months. When the relationships between the length of time in treatment and other variables were investigated, no significant differences were found in terms of gender, alcohol zone, or use of heroin in the last week. However, the mean length of time in treatment for those reporting that they had an alcohol problem was significantly lower than that of those who did not perceive their drinking as problematic. The mean length of time in treatment for those respondents who reported physical problems was significantly longer than that for those without such problems, although this may been related to their age. In contrast, the mean length of time in treatment for those clients who reported having legal problems was significantly shorter than those who did not.

Reported current daily doses of methadone in millilitres ranged from 6 to 95 mls. The mean dose was 43 mls and the modal dose was 50 mls. On investigation, no statistically significant relationships were found with other variables such as gender, alcohol consumption, or use of illicit drugs in the previous week.

In terms of how they felt about their current dose, those who felt that it was not enough were on average receiving higher doses (mean=48mls) than those who felt 'fine' (mean=42mls), who were in turn receiving higher average doses than those who felt their dose was too much (mean=27mls). 119 (91%) respondents' methadone use was supervised, the remaining 22 (9%) being unsupervised. Whereas the unsupervised clients were either ambivalent or happy with their arrangements, 24 (19%) and 19 (15%) supervised clients respectively were very unhappy or unhappy with their supervision arrangements.

Summary of results

The majority of clients (59%) indicated that they had current problems in three or more of the problem areas considered in the study. The most commonly cited problem areas were debt (50%), dental health (41%), physical health (40%), accommodation (34%), and mental health (33%). The problems with which clients indicated they needed the most help were debt, accommodation, dental health, mental health and physical health.

Many clients who indicated problems were not currently receiving help from services, particularly in the areas of debt, education/training, leisure and dental health. Where clients were not currently receiving help from services there was overall a high degree of reported willingness to use appropriate services if they were established locally – particularly in relation to living arrangements and drug problems. The degree of social support provided to respondents by family and friends varied widely depending on the type of problem. This was highest in relation to drug, mental health and physical health problems.

Discussion

Several issues can be identified as particularly problematic from the perspective of longer-term methadone clients. While the nature and extent of the debt problems reported by respondents may merit further investigation, it is clear that debt is a significant problem for a high proportion of clients. Debt problems were also found to be linked to potentially harmful levels of alcohol consumption and perceived alcohol problems, although it is unclear whether any link between these two issues was perceived by clients. The relative lack of emphasis on employment as a problem in spite of both this debt problem and high unemployment rates among clients may be related to a lack of readiness for entering employment, or may reflect a lack of focus on employment by treatment services. Given the considerable expressed interest in using an appropriate local service, the relative lack of availability or accessibility to existing debt management and welfare advice services should be a key focus of service and process mapping.

Accommodation is another problematic issue in which methadone clients appear to be generally disadvantaged compared to other Lanarkshire residents. Once again, the high level of motivation to use an appropriate local service and the fact that almost two thirds of clients reporting problems said they were not currently receiving help suggests that accommodation issues should be prioritised in terms of service and process mapping.

The three aspects of health enquired about in the study also emerged as relatively highly problematic issues for many respondents. Dental health in particular was an area in which most clients with problems were not currently receiving any help. The link between mental health problems and illicit drug use and the apparent concerns caused by physical problems, particularly in later stages of methadone treatment, emphasise the need for a more holistic inter-agency approach focussing on wider aspects of health and wellbeing.

Conclusion

Recovering drug users face a variety of problems in their lives, and their perceptions of these problems are not necessarily the same as those of external groups such as policy makers and service providers. As part of a process of needs assessment, it is important to assess the problems of recovering drug users as they perceive them. This information can then be considered alongside various other service demands and compared with the current supply of services through process mapping in order to assess areas of unmet need and desirable courses of action in light of resources and organisational priorities.

Limitations

Several factors may have served to limit the scope and accuracy of this study. Perhaps most importantly, for a variety of reasons, it turned out to be impossible to adopt the service-user involvement approach to the survey methodology that was initially intended. In the absence of this methodology, and in spite of guarantees of anonymity in the case of self-completion of the questionnaire, it is possible that clients may have been influenced by real or perceived expectations regarding their responses - particularly in relation to reporting sensitive or adverse issues such as alcohol and drug use and mental health problems.

A further two potential limitations may also have arisen from this methodological issue namely a potential lack of clarity regarding the issues of consent and anonymity, and the geographical skewing of the sample which prohibited the intended analysis at locality level. Finally, it is recognised that there may not have been sufficient scope in the questionnaire for clients to express problems that they were not specifically asked about. While a comments section was included for this purpose it was not used to any considerable degree.

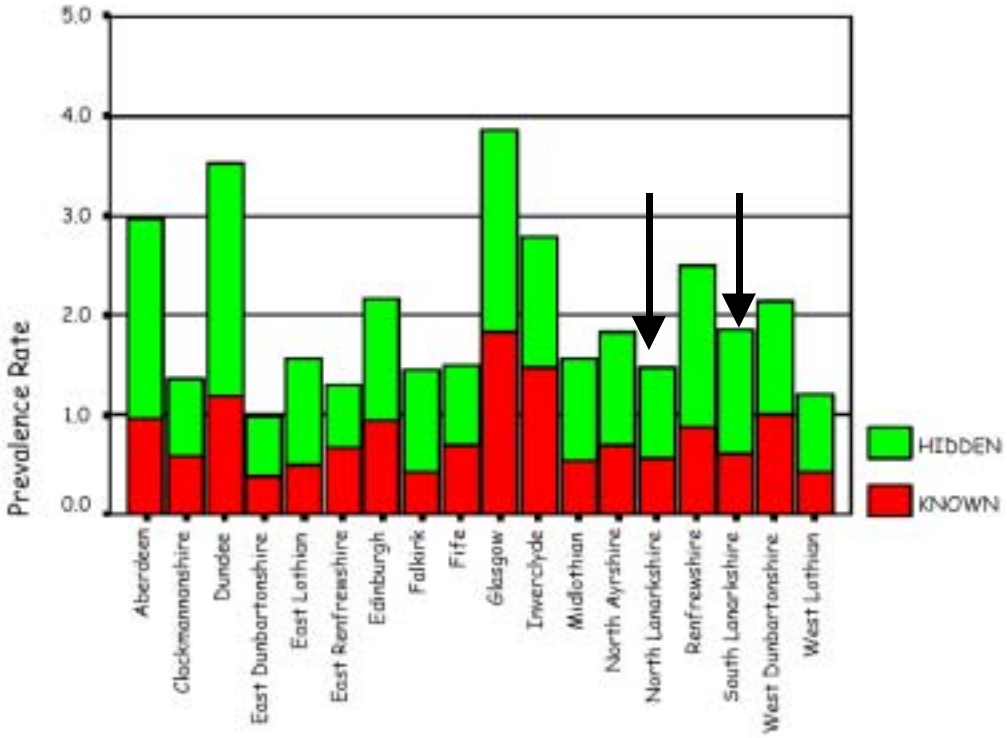
Introduction

Prevalence of heroin use

While general population surveys can provide information regarding the use of certain substances, estimating the prevalence of less common and more stigmatised drugs such as heroin requires the adoption of alternative research methods. The best available estimates of the prevalence of heroin use in Lanarkshire come from two studies employing capture/recapture[1] methodology.

The more recent National Prevalence Study (Hay et al. 2001) provided estimates of problematic drug misuse (defined as use of opiates and/or benzodiazepines) among 15-54 year-olds at the level of Local Authority and Action Team areas. As Chart 1 shows, in terms of prevalence rate by Local Authority Area, both North Lanarkshire (1.6%) and South Lanarkshire[2] (1.9%) are placed somewhere in the middle between the council areas with the highest and lowest rates.

Chart 1
Estimated prevalence of problem drug use by Council Area



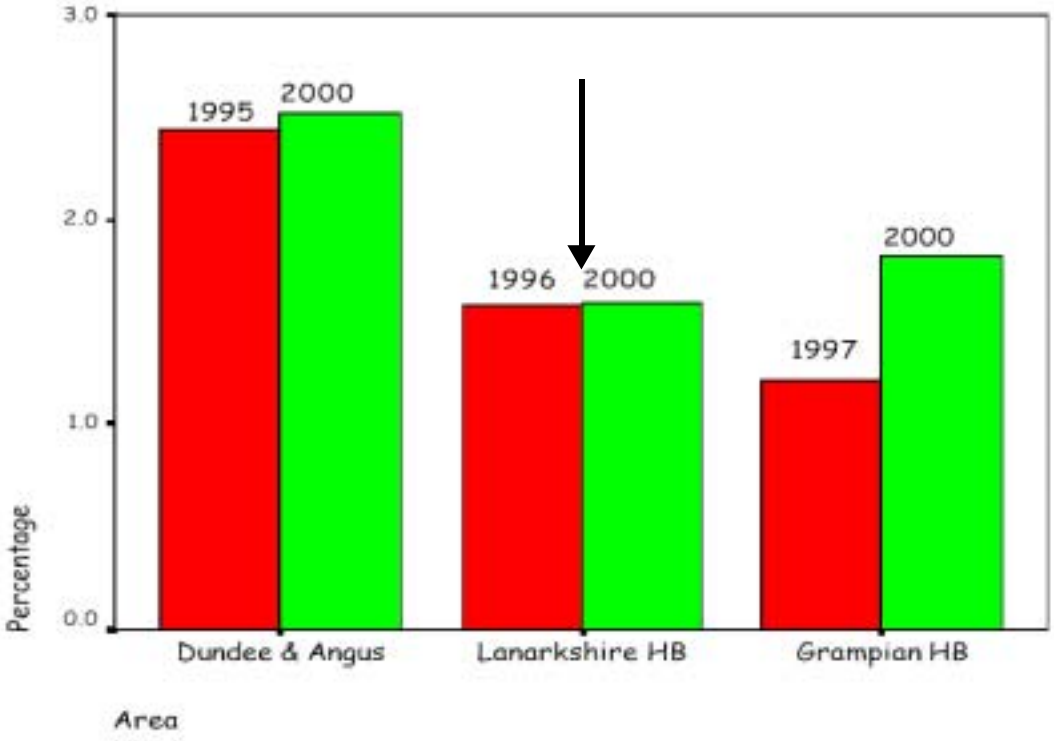
Source: Hay et al. (2001)

[1] See e.g. Kraus et al (2003) for an overview of prevalence estimate methodology

2 Both North and South Lanarkshire Council areas include areas outwith Lanarkshire ADAT area.

In terms of prevalence rate at the level of Action Team areas, Lanarkshire's rate of 1.6% shares 6th highest position with 3 other areas, and is below the Scottish average of 2.0%. Regarding change in prevalence rate over time, a comparison with the earlier local prevalence study (CDMR, 1997), which involved comparable methods and target groups, shows that the Lanarkshire rate has remained largely unchanged over the 4-year period (Chart 2). Based on year 2000 population estimates, a rate of 1.6% equates to over 5000 individuals.

Chart 2
Changes in the estimated prevalence of drug use



Source: Hay et al. (2001)

Clients attending treatment services

Information on **new**[1] patients/clients attending services in Lanarkshire can be gleaned from the Scottish Drugs Misuse Database (SDMD). As shown in Table 1, heroin has been the drug deemed to be the cause of the most problems[2] for the majority of people entering treatment for drug problems over the last few years. For the year ending 31st March 2001, this amounted to 364 individuals.

Table 1
Main drug of misuse reported by Lanarkshire residents referred to SDMD; by year

	1998/99 (%)	1999/00 (%)	2000/01 (%)	2001/02 (%)
Heroin	**66**	**66**	**71**	**75**
Other opiates	9	11	12	3
Benzodiazepines	14	12	4	3
Other drug types	11	11	12	11

Note: All figures in this table exclude penal establishments and information received from needle exchanges. Due to rounding percentages may not add up to 100%. Information for 2001/02 refers to illicit drugs only.
Source: Scottish Drug Misuse Database (ISD, 2003)

Methadone is the main treatment drug for opiate dependence used in Scotland. In a recent survey of Scottish NHS services for opiate dependents, half of clinicians who provided an estimate said that either all or nearly all of the opiate-dependent patients they saw were on methadone. The remaining estimates varied between 60% and 90% of patients (EIU, 2002a). While the estimated proportions of these patients that were on a scheme of maintenance varied considerably, the vast majority of clinicians surveyed estimated that more than half of all methadone patients were on maintenance programmes (*ibid.*).

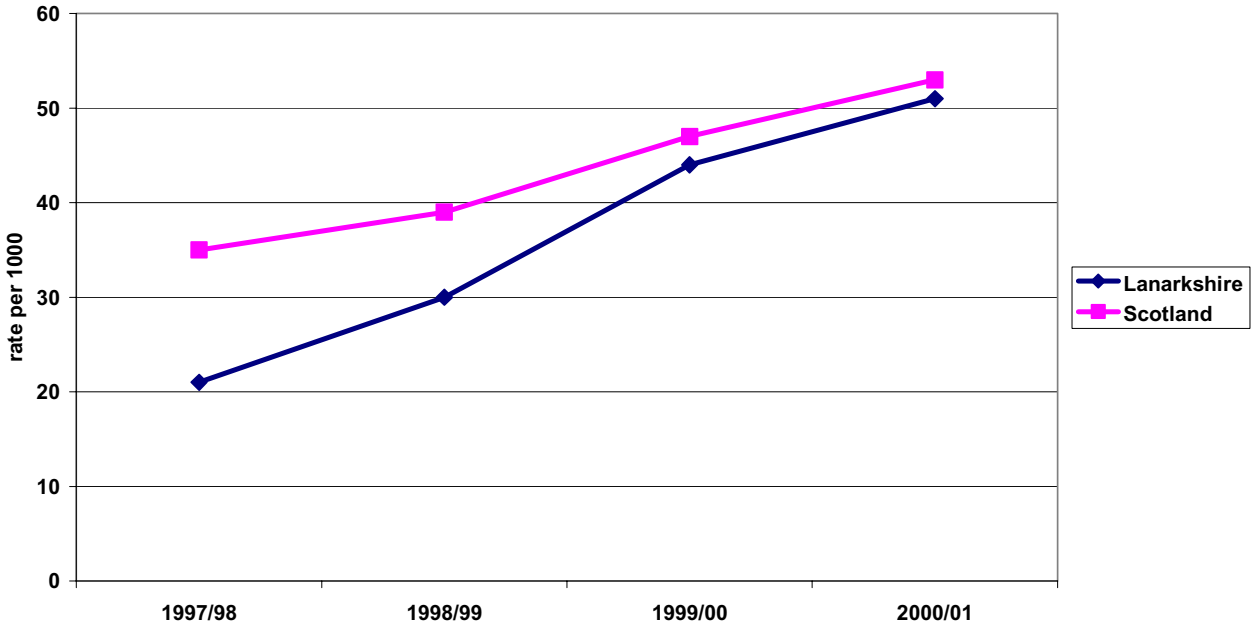
ISD prescription statistics can provide information regarding the total amount of methadone prescribed, the number of prescriptions, and the number of dispensings. As chart 3 shows, the number of methadone mixture[3] prescriptions has risen considerably over the last few years – even more so in Lanarkshire than in Scotland as a whole. In terms of the quantities involved, the total amount of methadone prescribed in Lanarkshire in 2000/01 amounted to almost 10,000 litres.

Gaining information regarding the actual number of *individual clients* who receive methadone is however less straightforward.

[1] Any person who is attending the services for (a) the first time ever or (b) it has been at least 6 months since the last attendance at the service (ISD, 2002)
[2] SMR24 guidelines define 'Main Drug' as *"The drug that causes the client the most problems at the time of contact"*
[3] This data excludes methadone linctus, tablets etc. that can be prescribed to control symptoms in terminal illnesses

Chart 3

Methadone prescriptions - rate per 1000 of population (Lanarkshire vs Scotland); by year

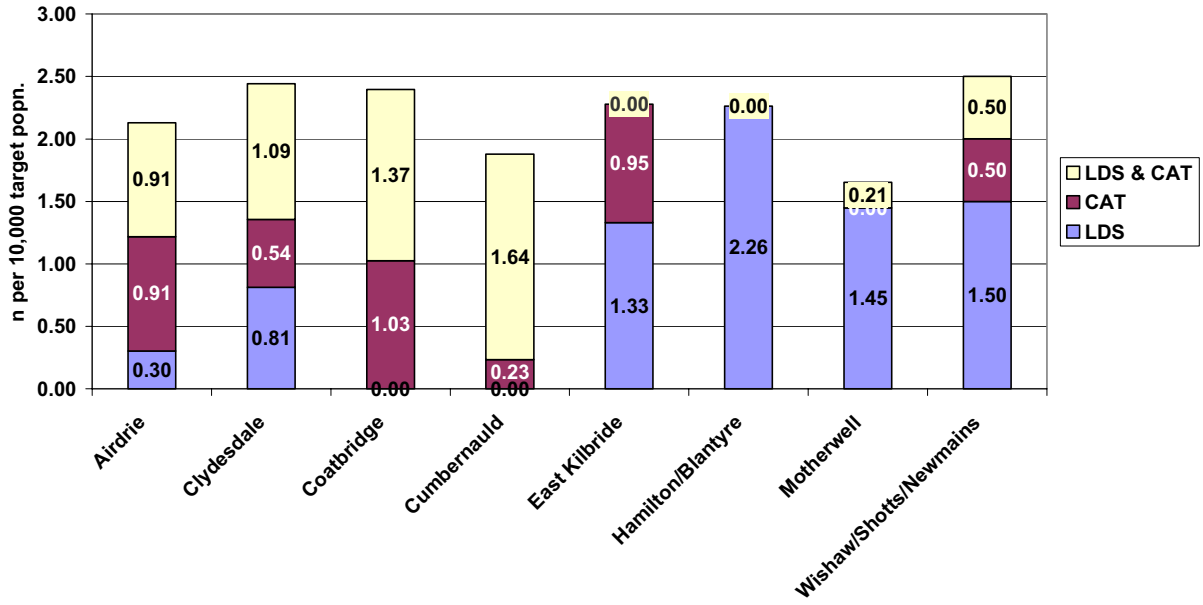


Source : ISD Scotland - Prescribing Information System (PIS).

Methadone treatment is provided in Lanarkshire by Lanarkshire Drug Service (LDS) and the three Community Addiction Teams (CATs), primarily through GP practice-based clinics. There are currently around 75 of these clinics in operation throughout Lanarkshire. As shown in Chart 4 there are between 1.5 and 2.5 clinics per 10,000 of the target population in each LHCC area, and the majority of clients attend clinics managed by LDS.

Chart 4

Number of GP practice-based methadone clinics per 10,000 target population (15-59); by agency and LHCC geographical area



Note: population figures based on CHI populations June 2000 weighted to GRO population estimates 2000

Information regarding LDS patients/clients is held on a central database used primarily to track payments made to GPs who prescribe methadone within the local "shared-care" scheme. According to the database, around 1250 individuals attended clinics in the year 2001/02.

This figure would seem to agree with a second source of information, namely a pilot project being conducted by ISD which aims to count the number of individuals being prescribed methadone in a given area within a given time period by scrutinizing actual scripts. While this is still very much a work-in-progress, preliminary data for Lanarkshire suggests a figure of around 1500 individuals.

In terms of the target group of the current survey, as at 1st October 2002 there were approximately 300 clients on the LDS database who fulfilled the criteria proposed to describe *current, long-term* methadone patients, namely:

a) They had attended a clinic within the last month; and
b) They had been in treatment for atleast 180 days.

Including Community Addiction Team and other methadone clinics it is therefore estimated that there are currently between three and four hundred such individuals in the Lanarkshire area.

Problems faced by methadone clients

As indicated in the recently published EIU document "Integrated Care for Drug Users", there is a wealth of evidence to suggest that recovering problem drug users often face difficulties in a variety of other areas of their lives (EIU, 2002b).

One such area is **accommodation**. Many of the participants in the National Treatment Outcome Research Study (NTORS) were found to have poor accommodation arrangements – a total of 20% were either living on the street, living in squats or in hostels in the three months prior to intake (Gossop, Marsden & Stewart, 1998). This issue was also raised at a local ADAT planning event in 2001 where service users identified "Difficulties of access to suitable housing" as a key issue in relation to service provision (Barlow, 2001).

A related issue is that of **living arrangements**. It is now widely recognised that drug problems have an affect on the whole family (EIU, 2002c) and there is a particular emphasis on the impact on dependent children (e.g. Barnard, 2001). Specific aspects of the home environment of a problem drug user that can be potentially problematic include: problems with neighbours, landlords or dealers; sharing with other drug users/problem drinkers; living in a drug-using/heavy drinking community; exposure of children to drug taking, intoxicated behaviour and criminal activities (Scottish Executive, 2003).

Relationship problems are another potential outcome of problem drug use. A recent qualitative study of families affected by a relative's drug use, for example, found that problems between spouses/partners could become so serious that they resulted in separation or divorce (EIU, 2002d).

Access to **leisure/recreation** is another issue which is often emphasised in relation to both prevention of problem drug use and social reintegration. A Scottish Executive funded evaluation of the impact of leisure interventions on illicit drug use and offending is currently underway.

As outlined in the EIU 'Moving On' review (EIU, 2001) the provision of support to recovering drug users to help them progress into **education, training and employment** is crucial to the process of social reintegration and rehabilitation. The importance placed on these issues in the conclusions of various surveys of recovering problem drug users (E.g. Buchanan and Young, 1996; McIntosh and McKeganey, 2001) has led to their prioritisation both nationally and at Action Team level. Problems relating to **benefits** can arise in this respect. Service users participating in the local ADAT planning event, for example, identified problems regarding the benefits system and job seekers' allowances which could lead to disincentives to look for work (Barlow, 2001).

The issues mentioned above can contribute to the general **financial** problems faced by many recovering drug users. Besides the potential for problems directly linked to the use of illicit drugs, recovering drug users can also have comparatively poor access to credit resulting in the incurring of debt through having to borrow money at higher rates (EMCDDA, 2001; Lupton et al, 2002)

Continued **illicit drug use and alcohol use** can also be problematic for recovering problem drug users. In the NTORS, for example, 50% of methadone clients treated in community settings reported regular use of heroin one year after intake (Gossop et al, 1998). At the 4-5 year follow-up the proportion had reduced to 42%. In terms of other illicit drugs, regular use of non-prescribed benzodiazepines was reported by 19% of methadone clients at one-year follow-up, and by 12% at 4-5 year follow-up. In terms of injecting and sharing of equipment, 45% and 5% respectively reported these behaviours at the one year follow-up in the same study. These proportions had reduced to 37% for injecting but remained at 5% for sharing.

In terms of **alcohol** consumption, research with methadone clients has produced widely varying results[1]. Regarding the NTORS data, one-year follow-up results indicated that 35% of methadone clients treated in community settings were abstinent from alcohol and that 23% were drinking more than the recommended weekly levels (*ibid.*). After 4-5 years this proportion had risen slightly to 25%. Several NTORS publications[2] have emphasised the seriousness of the threat to the health of methadone clients posed by heavy drinking in terms of increased potential for liver disease and drug overdose.

Addressing the **health**-related consequences of problem drug use is in fact a primary outcome of treatment programmes. However, one year follow-up data from NTORS showed that in spite of overall improvements in the **physical health** status of clients, many still faced significant problems in terms of physical symptoms such as chest pains, stomach pains and fatigue (*ibid.*). This led to the conclusion that the ongoing health problems of clients in treatment, which were related to blood-borne viral conditions in some cases, represented a significant cause for concern which merited appropriate recognition.

Dental health problems are likely to be incurred by recovering drug users for a complex variety of reasons reviewed in depth elsewhere (e.g. Titsas & Ferguson, 2002). In brief, tooth decay among recovering drug users may be associated with a combination of factors including general personal neglect, a shortage of money, a taste preference for sugary foods, reduced salivary secretion, the concentration of sugar in methadone, masking of dental pain, immuno-suppressive effects, untreated trauma and dentofacial injury, and the additive effects of associated tobacco, cannabis and alcohol use (*ibid.;* Griffiths et al., 2000). This may be particularly true for Lanarkshire and indeed Scotland due to the relatively poor level of dental health in the general population.

While the relationship between the two is varied and complex[3], it is clear that individuals with substance use problems often experience co-existing **mental health problems**. According to data reported to the Scottish Drug Misuse Database, these problems are consistently among the most commonly cited significant issues that lead to individuals' presenting to a service for their drug misuse problem (ISD, 2003). In addition, recent psychiatric treatment was reported by one in five NTORS participants and psychiatric symptom levels at treatment intake were high for many clients (Gossop, Marsden, Stewart,& Rolfe, 2000).

The majority of methadone clients in Lanarkshire have their consumption of methadone supervised by a pharmacist on a daily basis – around 80% of dispensings in 2002 were supervised (ISD, 2003). Through consultation with service users and their families, problems associated with **supervision** have been highlighted in relation to issues including lack of privacy, attending work or training programmes, and mixing different cohorts of users – i.e. those who are less stable and those who are motivated to change (Barlow 2001).

Finally **legal problems** as a result of criminal behaviour can be a significant issue for methadone clients. For instance, a criminal record can serve as a considerable barrier to employment. Pending court cases can also be seen as a substantial problem for methadone clients, as incarceration can impact on clients' methadone treatment programs. Almost three quarters of NTORS clients had been arrested in the previous two years (Gossop et al 1998).

[1] See Lowe & Shewan (1999) for a brief review
[2] e.g. Gossop et al. (1998), Gossop et al. (2000), Gossop et al. (2002)
[3] See e.g. DOH (2002)

Aim

The aim of this study was to investigate the needs of longer-term methadone clients, from their perspective, in relation to the range of problem areas identified above.

This study was carried out in the context of a wider and ongoing needs assessment. As part of the forthcoming ADAT 3-year strategy, an updated profiling of all drug and alcohol treatment and support services will be undertaken. It is also envisaged that upgraded information systems across all services will be capable of providing accurate information regarding service activity in relation to a variety of specific treatment modalities/support interventions, related waiting times, and unmet assessed needs.

As seen in the information presented above, the provision of methadone treatment has expanded considerably in the last few years. It remains unclear however whether all methadone clients are currently receiving the holistic, person-centred service required to maximize the benefits from methadone treatment and facilitate social inclusion.

Methods

A cross-sectional survey was conducted in a variety of LDS and CAT-managed methadone clinics in Lanarkshire in Autumn 2002. The participants comprised a convenience sample of 131 clients who had been attending methadone clinics for a period of more than six months. The survey instrument was distributed as a self-completion questionnaire by clinic nurses and then returned in a sealed envelope to a box at the clinic reception. Alternatively the survey could be administered as a structured interview where deemed appropriate.

The specific areas of need investigated included: accommodation; living arrangements; relationships; education/training; leisure/recreation; physical health; alcohol & other drugs; treatment status; mental health; employment; financial situation; and legal situation.

As wells as eliciting a description of respondents' current situation, which was compared to general population data for Lanarkshire where possible, questions within each section were designed to assess:

- whether respondents perceived this area as a problem;
- how much help they needed with the problem;
- whether they were already getting help from services;
- whether they would use an appropriate service if it was set up in their area; and
- whether their family or friends helped with this problem.

Data was single-entered into MS Access and then converted into SPSS for analyses. A 10% check revealed two errors which were subsequently corrected. This error rate of 0.12% (13 records x 124 variables) was considered to be acceptable. For continuous variables t-tests and One-way ANOVAs were used to compare groups. Relationships between categorical variables were analysed using Chi-Square and Fisher's Exact Test where appropriate. All tests were two-tailed unless otherwise stated. Significance level was set at 0.05.

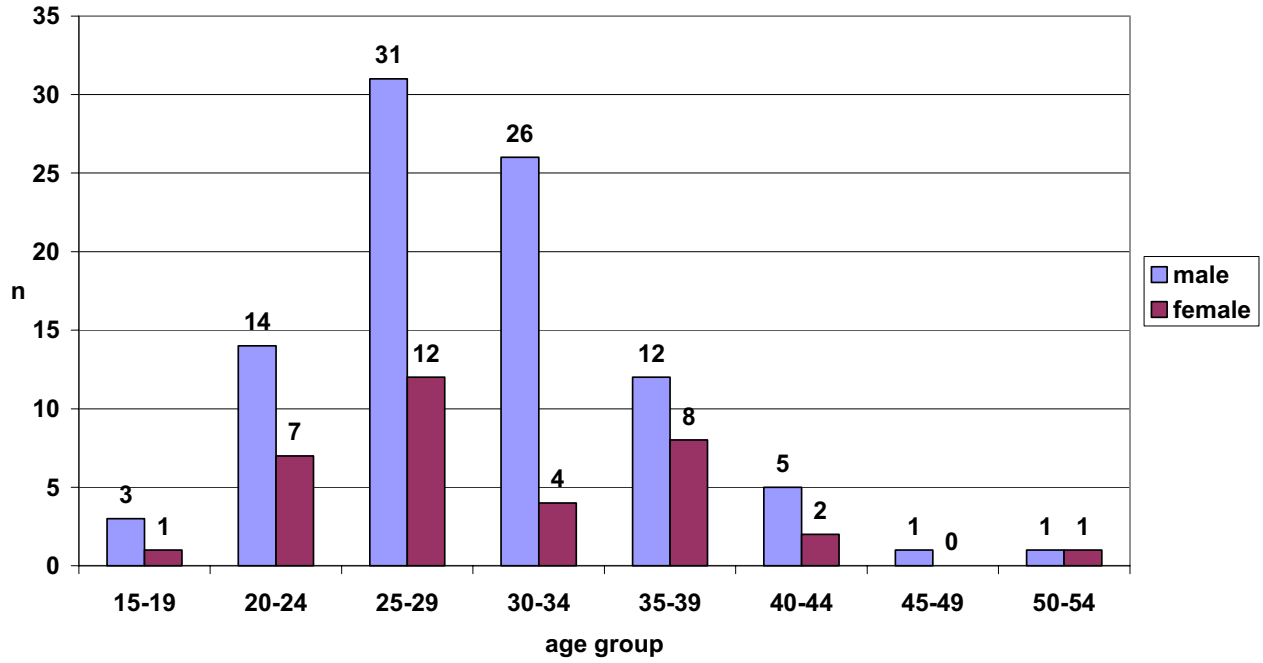
Results

Demographic characteristics

Of the 131 clients surveyed, 96 (73%) were male and 35 (27%) were female. While this proportion is broadly consistent with figures relating to clients in treatment[1] and problem drug users in the general population[2], it is possible that females were slightly underrepresented[3] in the sample. The average age for both males and females was 30 years (range 18–52). The age and gender distribution of responding clients is shown in chart 5.

Chart 5

Age group distribution of respondents; by gender



[1] E.g. NTORS clients consisted of 74% males and 36% females

[2] E.g. Hay et al. (2001) – males constituted between 67% and 77% of the estimated total population in the ten Council areas with the highest prevalence of problematic drug misuse.

[3] Approximately 33% of long-term clients attending LDS clinics as at October 2002 were female.

Accommodation

As shown in table 2, the majority of responding clients lived in non-private rented accommodation. Around a quarter either owned or privately rented their house, and a relatively small number of respondents were either homeless (n=9) or living in supported accommodation (n=2). None of the respondents described themselves as 'roofless' i.e. sleeping on the streets.

Table 2
Accommodation status of responding methadone clients and all Lanarkshire households

	Survey respondents (n)	Survey respondents (%)	LHB residents[X] (%)
Rented (Council/Housing association)	88	67.2	32.2*
Owned	18	13.7	61.8**
Rented (Private)	13	9.9	6.0***
Subtotal (households)	*119*	*90.8*	*100*
Homeless (eg. B&B/hostel/crashing with friends)	9	6.9	
Supported	2	1.5	
Roofless	0	0	
Missing	1	0.8	
Total	**131**	**100**	

[X] Source: GROS (2003)
* includes local authority, Scottish homes, housing association & shared ownership
** includes owns outright & owns with a mortgage or loan
*** includes private landlord or letting agency, employer of a household member, and relative or friend of a household member

The accommodation status of respondents living in households is considerably different from that of Lanarkshire residents generally, as reported in the 2001 census study. Regarding respondents who indicated that they were homeless, the figure of around 7% can be compared with a Lanarkshire average of around 1.5% based on applications of homelessness to local authorities[1].

[1] No. of households that applied as homeless to local authorities under the homeless persons legislation during 2001-02 (Scottish Executive, 2002) expressed as a percentage of the combined number of households in North and South Lanarkshire.

Accommodation problems

As shown in table 3, 45 (35%) of respondents indicated that their accommodation was a problem. Of these, 16 were already getting help from services and 25 of the remaining 29 said they would use an appropriate service if it was set up in their area. In addition, 19 respondents said that their family or friends helped them with their accommodation problems.

When asked how much help they need with this problem, most responded that they need a *high* amount (17%) or *some* (14%) help. Regarding those in most need, 2 of 18 (11%) homeowners, 13 of 88 (15%) respondents who rented from the council or a housing association, 3 of 13 (23%) who rented privately, 3 of 9 (33%) homeless and 1 of 2 (50%) supported clients indicated that they need a *high* amount of help with their accommodation problem.

Table 3
Number of respondents indicating problem with accommodation, and amount of help required; by accommodation status

		Problem - Amount of help required						
Accommodation status	No problem	None	Low	Some	High	Missing	Total (problem)	**Grand Total**
Owned	16	0	0	0	2	0	(2)	**18**
Rented (Council)	60	3	0	12	13	0	(28)	**88**
Rented (Private)	7	0	0	2	3	1	(6)	**13**
Homeless	2	0	0	3	3	1	(7)	**9**
Supported	0	0	0	1	1	0	(2)	**2**
Total (n)	**85**	**3**	**0**	**18**	**22**	**2**	**(45)**	**130**
Total (%)	**65%**	**2%**	**0%**	**14%**	**17%**	**2%**	**(35%)**	**100%**

Missing=1

Living arrangements

The living arrangements of clients in terms of household composition are shown in table 4. The majority of respondents lived with their parents, their partner or alone. A total of 24 respondents indicated that they lived with dependent children.

Table 4
Number of respondents indicating problem with living arrangements, and amount of help required; by living arrangement status

	No problem	Problem – amount of help required					
Living arrangements		none	low	some	high	Total (problem)	**Grand total**
With parents	34	1	0	2	3	(6)	**40**
With partner	27	0	0	2	0	(2)	**29**
alone	21	0	0	2	3	(5)	**26**
With partner & dependent children	6	0	0	0	5	(5)	**11**
With dependent children	6	0	0	3	1	(4)	**10**
With other relatives	3	0	0	0	0	(0)	**3**
With other housemates	2	0	0	0	1	(1)	**3**
With partner & parents	2	0	0	0	0	(0)	**2**
With friends	1	0	0	1	0	(1)	**2**
With partner, dependent children, other relatives & other housemates	0	0	0	0	1	(1)	**1**
With partner, dependent children & other relatives	0	0	0	0	1	(1)	**1**
With parents & other relatives	1	0	0	0	0	(0)	**1**
With parents & dependent children	1	0	0	0	0	(0)	**1**
Total (n)	**105**	**1**	**0**	**10**	**15**	**26**	**131**
Total (%)	**80%**	**1%**	**0%**	**8%**	**11%**	**(20%)**	**100%**

Living arrangement problems

Twenty-six (20%) of respondents indicated that their living arrangements were a problem. Of these, ten were already getting help from services and all of the remaining 16 said they would use an appropriate service if it was set up in their area. Thirteen respondents said that their family or friends helped them with these problems.

When asked how much help they need with this problem, most responded that they need a *high* amount (11%) or *some* (8%) help. Most respondents who lived alone, with a partner and dependent children, or with a variety of relatives indicated that they need a *high* amount of help. When asked to describe their problems, the main issue raised was overcrowding (n=11). Other problems included homelessness (n=3), living in a bad area (n=2), problems with caring for dependent children (n=2), problems related to self care (n=2), and problems with neighbours (n=2). One respondent each indicated that their house was too big, and simply that their living arrangements were “unsuitable”.

Relationships

Table 5 shows the relationship status of responding clients. Most respondents were single or living with a partner. A relatively small proportion of respondents described themselves as married, separated or divorced. Due to the lack of availability of age-specific census data it was not possible to compare relationship status of respondents with that of age-matched Lanarkshire residents.

Table 5
Relationship status of responding methadone clients

	N	%
single	72	54.96
partner	37	28.24
married	7	5.34
separated	6	4.58
divorced	4	3.05
widowed	0	0.00
Total	**126**	**100**
	missing = 5	

Relationship problems

Eleven (8%) of clients expressed that they had significant relationship problems. Most of these problems related to strain on spousal relationships due to drug problems (e.g. “marital strain due to addiction”, “pressure on relationship through drug use”). Of these, two were already getting help from services and 4 of the remaining 9 said they would use an appropriate service if it was set up in their area. Five respondents said that their family or friends helped them with these problems. In terms of the amount of help needed with relationship problems, four respondents indicated *some* help and two indicated a *high* amount of help.

Education/training

The highest qualification levels of the sample are shown in chart 6. Fifty-nine (45%) respondents indicated that they had no formal qualifications. Around half indicated that they were educated to O-grade/standard grade level (n=35) or had attained qualifications through further education (n=31). Three respondents had Highers/A-level equivalents and one individual had a degree. While the use of different categories of qualification levels in the 2001 Census study makes it difficult to provide general population comparisons for Lanarkshire, these can be made for those with no qualifications and those with degrees as per table 6.

Chart 6

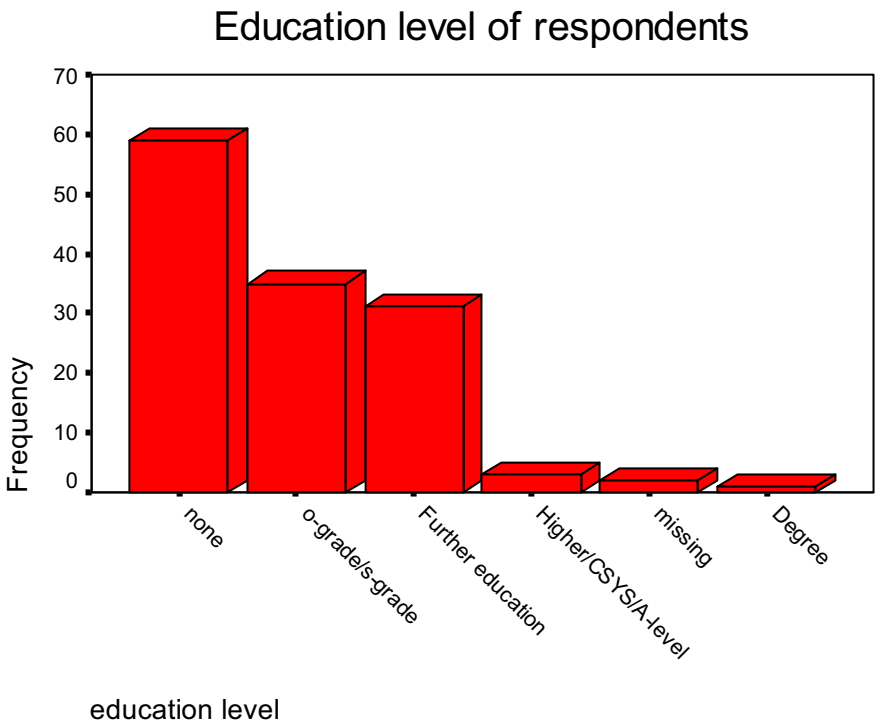


Table 6
Selected education levels of responding methadone clients and all Lanarkshire residents

	Survey respondents (n)	Survey respondents (%)	LHB residents[X] (%)
No qualifications	59	45	37.61
Degree	1	0.76	13.94

[X] Source: GROS (2003)

Education/training problems

Thirty-eight (29%) responding clients indicated that their education/training qualifications were a problem. Of these, 24 had no qualifications, ten had 'O' or 'S' grades and four had further education qualifications. Of those who indicated education/training problems, three were already getting help from services and 30 of the remaining 35 said they would use an appropriate service if it was set up in their area. Nine respondents said that their family or friends helped them with these problems. Over 90% of those indicating that they had problems required *some* (n=20) or a *high* (n=12) amount of help.

Leisure/recreation

Clients were asked how many hours a week they spent using council or private leisure facilities such as gym, swimming, 5-a-side etc.. While no direct comparison is available, this can be compared with certain aspects of the 1996 LHLS, i.e. the total number of hours in the last week engaged in:

- Dancing;
- Aerobics/gymnastics/exercises;
- Golf/bowls;
- Swimming for pleasure;
- Competitive sports or training (e.g. squash, football, cycling, swimming, netball); or
- Athletics/running/jogging.

Table 7
No. of hours spent using council or private leisure facilities; by sample

	LHLS (1996)	L/T methadone clients
Proportion spending 0 hours	49.7%	82.4%
Of those spending more than 0 hours:		
Minimum	0.03 hours	1 hour
Maximum	150 hours	10 hours
Mean	4.36 hours	4.27 hours
Median	3.00 hours	3.00 hours

Note: LHLS data has been age-matched to current sample range i.e. 18-52 years-old

Of the current sample, fewer that 1 in 5 individuals reported spending any time using council or private leisure facilities. This compares to around half of respondents in the LHLS. Of those who did use these facilities, the number of hours per week ranged from 1 to 10 and the average time spent was 4.27 hours per week.

Leisure/recreation problems

Thirty-seven (28%) respondents indicated that lack of access to leisure facilities was a problem for them. Of these, three were already getting help from services and 30 of the remaining 34 said they would use an appropriate service if it was set up in their area. Five respondents said that their family or friends helped them with these problems.

Thirty-two of those reporting problems with accessing leisure facilities were among the 108 individuals who indicated that they never used any such facilities. Of the remaining five respondents, four spent 1 or 2 hours using leisure facilities and one spent 5 or 6 hours.

Alcohol

Clients were asked to estimate how much alcohol they had drunk in the last week, and their responses were converted into units. Sixty-nine (54%) responding clients said that they had not drunk any alcohol in the last week. Of those who drank alcohol in the last week, the number of units consumed ranged from 2 to 300[1], and the mean number of units was 39. For the purposes of comparison to the general population of Lanarkshire, responses have been categorised into 'zones' in terms of drinking behaviour as per the 1996 LHLS, i.e.:

Zone	***Men***	***Women***
Sensible	0-21 units	0-14 units
Warning	22-50 units	15-35 units
Dangerous	>50 units	>35 units

Chart 7 and table 8 compare the drinking zones of the current sample with that of the 1996 LHLS. Overall, the distribution of the current sample across the various drinking zones is significantly different[2] from those of the 1996 Lanarkshire Health and Lifestyle Survey respondents. Proportionately more long-term methadone clients fell into the 'none' and 'dangerous' categories, while less were in the 'sensible' zone and a comparable proportion in the 'warning' zone. A total of 25% of the sample had drunk more than the recommended limits in the week prior to the survey. This is comparable with NTORS findings that 23% of community methadone clients were drinking more than recommended limits both at intake and 1 year follow-up (Gossop et al, 2000).

Chart 7

Alcohol consumed in the last week defined by drinking zones; by sample

[1] This figure is based on the reported consumption of 25 bottles of 'wine' (probably tonic wine) in the previous week
[2] Pearson's Chi-Square = 31.581, p=.000

Table 8
Alcohol consumed in the last week defined by drinking zones; by sex, age group and sample

Column percentage %

	male				female				Total	
	age groups				age groups					
	15-34		35-54		15-34		35-54			
none	24	49	25	53	40	57	40	91	39	54
sensible	37	20	43	32	46	22	51	0	42	20
warning	29	19	25	11	11	17	8	0	16	16
dangerous	9	12	7	5	2	4	1	9	4	9
Base N(=100%)		**74**		**19**		**23**		**11**		**127**

Key: LHLS (1996)
L/T methadone clients (2002)

Alcohol problems

Fourteen respondents (11%) indicated that their alcohol use was a problem. Of these, five were already getting help from services and 7 of the remaining 9 said they would use an appropriate service if it was set up in their area. Five respondents said that their family or friends helped them with these problems.

The majority of those reporting alcohol problems said they need some (n=7) or a high amount (n=5) of help. As shown in table 9, most of those needing some help were in the warning zone, and all of those who reported needing a high amount of help were in the dangerous zone. It should however be noted that only one third of those in the warning zone and half of those in the dangerous zone reported that their alcohol consumption was a problem.

Table 9
Number of respondents indicating alcohol problem, and amount of help required; by drinking zone

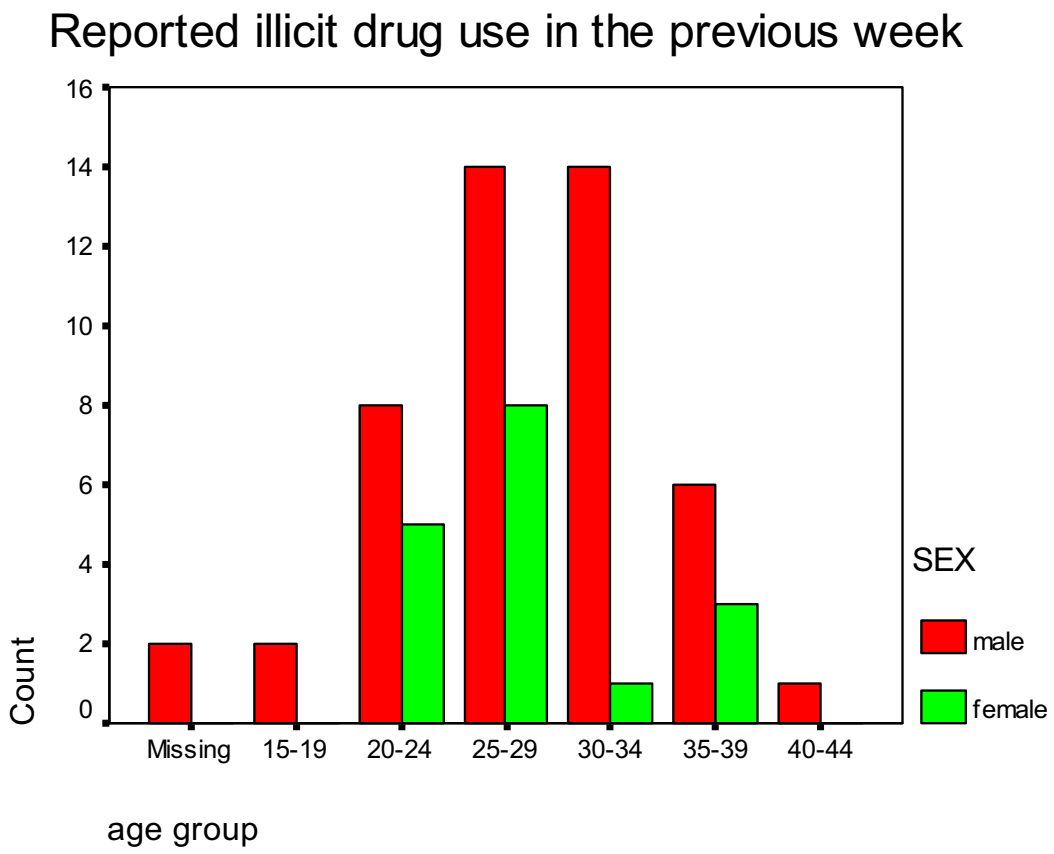
		Problem - Amount of help required					
Drinking zone	No problem	None	Low	Some	High	Total (problem)	**Grand Total**
none	70	-	-	-	-	-	**70**
sensible	26	-	-	1	-	(1)	**27**
warning	14	-	2	5	-	(7)	**21**
dangerous	6	-	0	1	5	(6)	**12**
Total (n)	**116**	**-**	**2**	**7**	**5**	**(14)**	**130**
Total (%)	**89%**	**-**	**2%**	**5%**	**4%**	**(11%)**	**100**

Missing=1

Illicit drugs

Responding clients were asked to indicate whether they had used any drugs besides prescribed methadone and alcohol in the last week, and if so to report which drugs, the quantity, and the route of ingestion. A total of 64 respondents (49%) reported using illicit drugs in the week prior to the survey (see chart 8). The difference in average age between those who reported using illicit drugs in the previous week (29 years) and those who did not (31 years) was statistically significant[1].

Chart 8



[1] Independent samples t test, t = 2.114, p = 0.036

As shown in chart 9, cannabis was the most frequently cited type of drug followed by heroin and benzodiazepines - very few respondents indicated use of cocaine or crack. Nine respondents (7%) indicated having injected drugs in the previous week, and three of these reported having shared injecting equipment. In terms of gender differences, proportionately more females reported having used heroin and having injected in the previous week – both of these results approached statistical significance[1]. The range and average quantities of selected drugs are shown in table 10.

Chart 9

Frequency of drugs indicated; by drug type

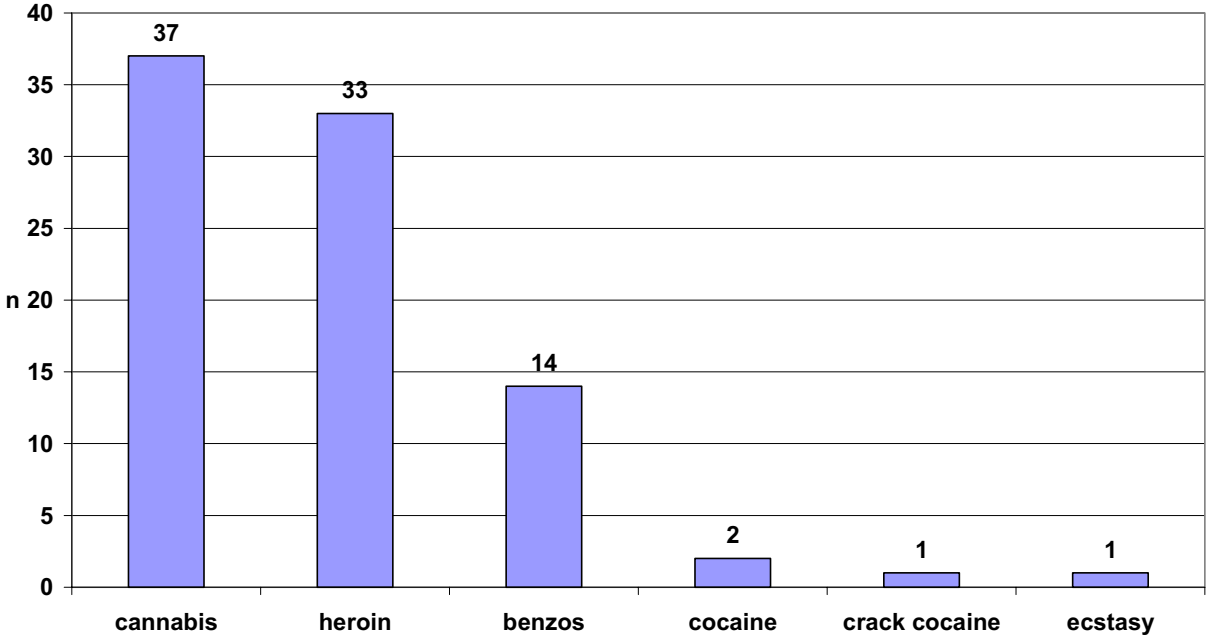


Table 10
Quantities of selected drugs used in the last week

Drug	Mean	Min	Max	N	Missing
Cannabis	7.6 grams	0.3 grams	28 grams	37	2
Heroin	2.3 bags (mode=3)	0.33 bags	21 bags	33	1
Benzodiazepines	23.7 tablets (mode=6)	2 tablets	112 tablets	14	1

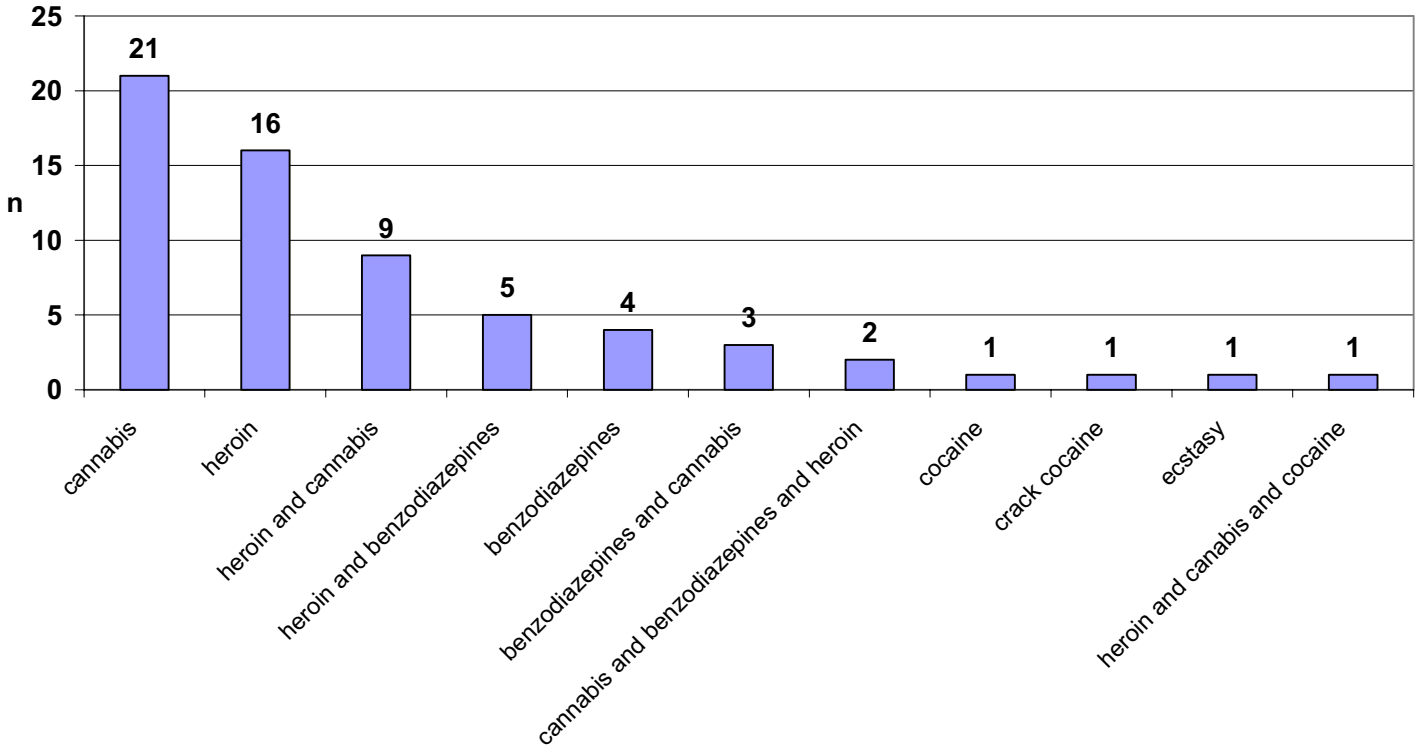
note: due to use of more than 1 drug by some individuals, total n does not add to 64

[1] Heroin use – Pearson Chi-Square = 3.620, $p = 0.057$, injecting – Fisher's Exact Test = 0.057

Chart 10 shows the different combinations of drugs reported by each individual who reported drug use. Sole use of cannabis and heroin were the most frequently cited types of drug use. In terms of polydrug use a total of 19 respondents indicated combining 2 or more of heroin, cannabis and benzodiazepines. Eleven respondents who reported using heroin and/or benzodiazepines were in the warning or danger zones for alcohol use. Regarding 'problem' drug use, as per the definition used in the national prevalence study, a total of 40 (30.5%) individuals reported use of heroin and/or benzodiazepines.

Chart 10

No. of clients using drugs in the last week; by drug type



Drug problems

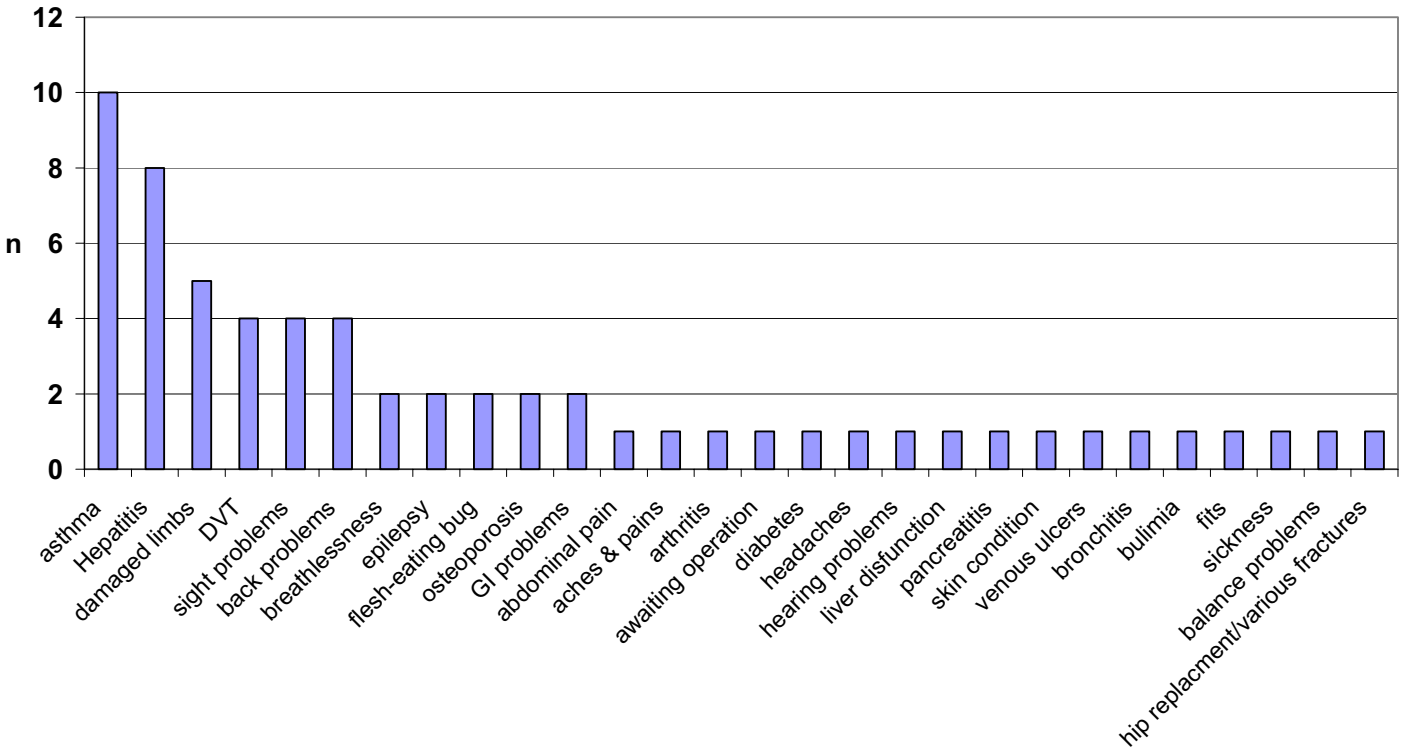
Thirty-two (24%) respondents indicated that their use of drugs besides methadone and alcohol was a problem. Of these, 26 were already getting help from services and all of the remaining six said they would use an appropriate service if it was set up in their area. A total of 22 respondents said that their family or friends helped them with their drug problems. The majority of those reporting drug problems said they need some (n=14) or a high amount (n=13) of help.

Physical health

A total of 52 (40%) responding long-term methadone clients stated that they had physical health problems. This compares to a figure of around 30% of respondents in the 1996 LHLS between the ages of 16 and 54 who said they had a long-standing illness, disability or infirmity. Of the 52 respondents with physical health problems, 38 were already getting help from services and 10 of the remaining 14 said they would use an appropriate service if it was set up in their area. Thirty respondents said that their family or friends helped them with these problems. Chart 11 shows the kinds of problems indicated by responding clients.

Chart 11

Physical problems indicated by responding clients



Asthma, hepatitis and damaged limbs were the most commonly cited types of physical problems. While the proportion (7.6%) of those reporting asthma problems appears particularly high, it is actually lower than the prevalence rate of asthma among adults in Lanarkshire as reported in the 1998 Scottish Health Survey[1] (13.2% of men, 12.8% of women). The Scottish Health Survey data, however, included responses of older individuals up to age 74. Of the 50 individuals who indicated how much help they needed with their physical health problems, most said they needed *some* (n=27) or a *high* (n=11) amount of help.

[1] Scottish Executive Department of Health. (2000)

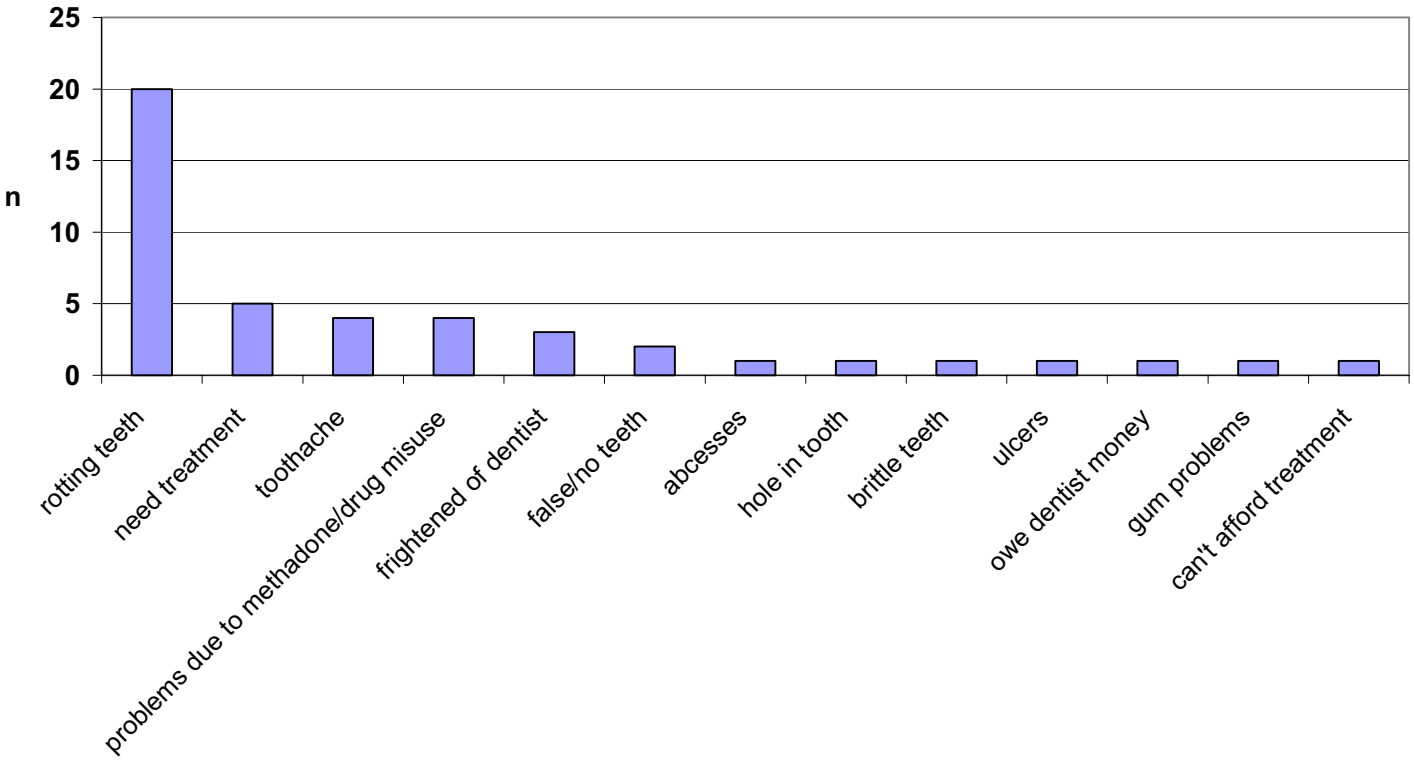
Dental health

Fifty-four (41%) respondents indicated that they had problems with their teeth or mouth. Of these, 21 were already getting help from services and 20 of the remaining 33 said they would use an appropriate service if it was set up in their area. Four respondents said that their family or friends helped them with these problems.

While comparable information for the general population in Lanarkshire is not available, an indicator of dental health problems in the LHLS (1996) is the proportion of people had less than 20 teeth. The proportion for the 16-54 age range was 26%. Chart 12 shows the types of dental problems indicated by 40 respondents in the current survey who provided this information. Rotting teeth was the most commonly cited type of dental health problem. Of the 47 respondents who indicated how much help they needed with this problem, most said they needed *some* (n=27) or a *high* (n=13) amount of help.

Chart 12

Dental health problems indicated by respondents



Mental health

Forty-three (33%) respondents indicated that they had mental health problems - proportionately more females (46%) than males (28%)[1]. Of these 43 clients, 23 were already getting help from services and 18 of the remaining 20 said they would use an appropriate service if it was set up in their area. Twenty-eight respondents said that their family or friends helped them with these problems.

It is recognised that these accounts of mental health problems are subjective and are not necessarily directly comparable with other information gained by different methods. However, it is worth noting that mental health was indicated as a presenting issue[2] for 45% of new Lanarkshire referrals to the SDMD in 2001/2002 (ISD, 2003). In terms of the general population in Lanarkshire, Table 11 shows related data from the 1996 LHLS, where 60% of respondents indicated medium or high stress levels and 34% indicated medium or high depression levels.

Table 11
Stress and depression levels* indicated by 1996 LHLS respondents

	Low (1-3)	Medium (4-7)	High (8-10)	Total
Stress level	40%	50%	10%	100%
Depression level	66%	28%	6%	100%

*stress and depression levels were indicated on a scale of 1 to 10 where 1 = not stressed/depressed and 10 = totally stressed/depressed

Table 12 shows the types of mental health problems indicated. Depression was the most frequently cited problem, followed by paranoia and anxiety. Of the 43 clients who indicated mental health problems, 19 cited 1 problem, 13 cited 2 problems and 10 cited three problems. Of the 43 respondents who indicated how much help they needed with this problem, most said they needed *some* (n=25) or a *high* (n=14) amount of help.

Table 12
Types of mental health problem indicated by clients

mental health problem	No. of clients	mental health problem	No. of clients
depression	31	lack of concentration	1
paranoia	11	low self-esteem	1
anxiety	9	mood swings	1
panic attacks	6	murder	1
agoraphobia	4	paranoid schizophrenia	1
stress	2	prescribed "largactil"	1
get worked up	1	sometimes lash out	1
head injury	1	suicidal tendencies	1
insomnia	1	auditory hallucinations	1

Note: total n does not add up to 42 as more than one problem could be indicated by each client

When those who indicated they had mental health problems were compared with those who did not, no significant differences were found in terms of reported alcohol consumption, reported use of heroin in the last week, length of time in treatment, current methadone dose, or age-group. Respondents who indicated mental health problems were however more likely to have indicated *problems* with illicit drug use[3], and to have reported use of benzodiazepines[4] or cannabis[5] in the last week.

[1] This difference approached statistical significance - Pearson Chi-Square = 3.599, p = 0.58.
[2] Presenting issues are defined as 'The significant issues that have led the person to present to the service/practice for their drug misuse problem'. (ISD, 2001)
[3] Pearson Chi-Square = 7.914, $p = 0.05$
[4] Fisher's Exact significance (1-sided) = 0.043
[5] Pearson Chi-Square = 8.963, $p = 0.003$

Economic/financial situation

The employment/economic status of respondents is shown in table 13. The majority (67.2%) of respondents described themselves as unemployed. While the inclusion of older individuals in the national census means that the data are not exactly comparable, the employment status of long-term methadone clients appears to be very different to that of the general population in Lanarkshire (see chart 13).

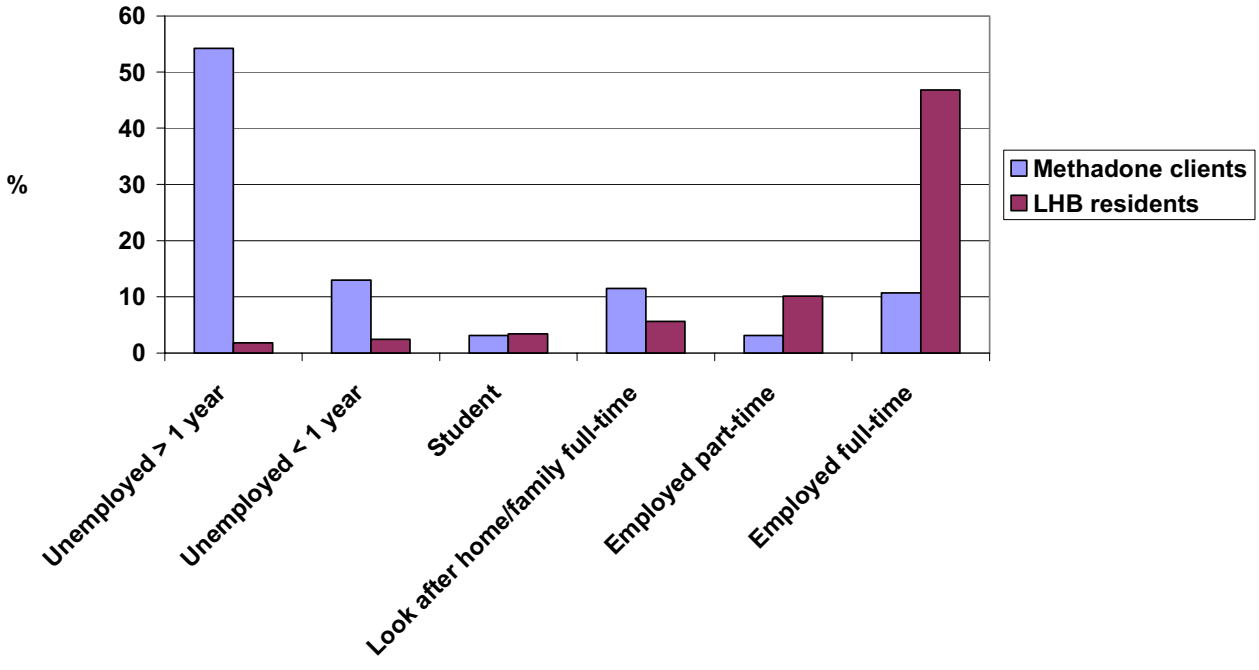
Table 13
Economic activity of long-term methadone clients and LHB residents* (GROS 2003)

	Methadone clients		LHB residents
	Frequency	**Percent****	**Percent****
Unemployed > 1 year	71	54.2	1.8[x]
Unemployed < 1 year	17	13.0	2.4
Student	4	3.1	3.4
Look after home/family full-time	15	11.5	5.6 [xx]
Employed part-time	4	3.1	10.1
Employed full-time	14	10.7	46.8
missing	6	4.6	-
other	-	-	29.9 [xxx]
Total	**131**		

*all people aged 16-74
**does not add to 100 due to rounding
[x] includes those who have never worked
[xx]includes self-employed
[xxx] includes retired, permanently sick/disabled

Chart 13

Economic activity of long-term methadone clients and LHB residents



Benefits

Respondents who were not in full-time employment were asked to indicate which benefits they were currently receiving. Table 14 shows the number and proportions of respondents who indicated that they received each type of benefit. National statistics[1] data are prevented for comparison where available. Income support and incapacity benefit were being claimed by a far higher proportion of methadone clients than other LHB residents. As chart 14 shows, most respondents who indicated that they received benefits reported that they received only one type of benefit. Income support alone was the most commonly reported benefit.

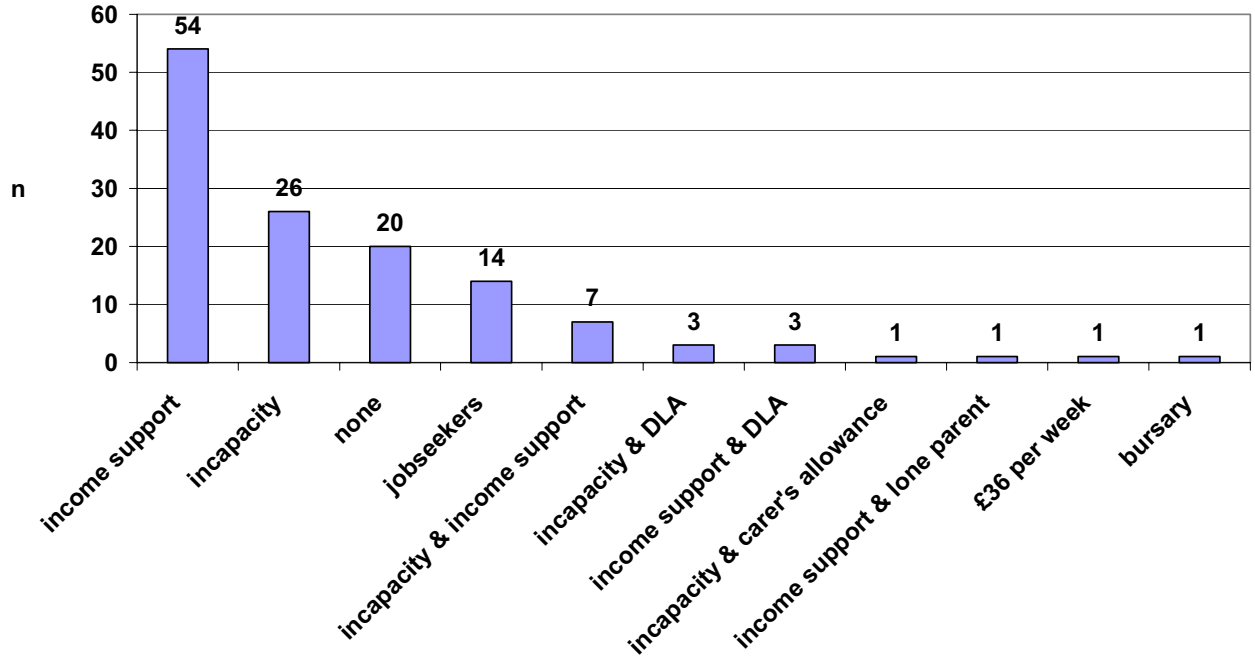
Table 14
Benefits received by long-term methadone clients and LHB residents* (GROS 2003)

	Methadone clients		LHB residents
	Frequency	Percent	Percent
Income support	65	49.6	13.6
Incapacity benefit	37	28.2	12.4
Jobseeker's allowance	14	10.7	-
Disability living allowance	6	4.6	9.4
Other	5	3.8	-

*all people aged 16-64
- unavailable

Chart 14

No. of responding clients receiveing benefits; by benefit type



[1] This data has been approximated by averaging the percentage data for North Lanarkshire and South Lanarkshire. Benefit claimant data are as at August 2000. Percentages have been calculated using 2001 Census data relating to 16-64 yr-olds.

Employment problems

Thirty-three (25%) respondents indicated that their employment situation was a problem for them. Of these, 5 were already getting help from services and 25 of the remaining 28 said they would use an appropriate service if it was set up in their area. Eleven respondents said that their family or friends helped them with these problems.

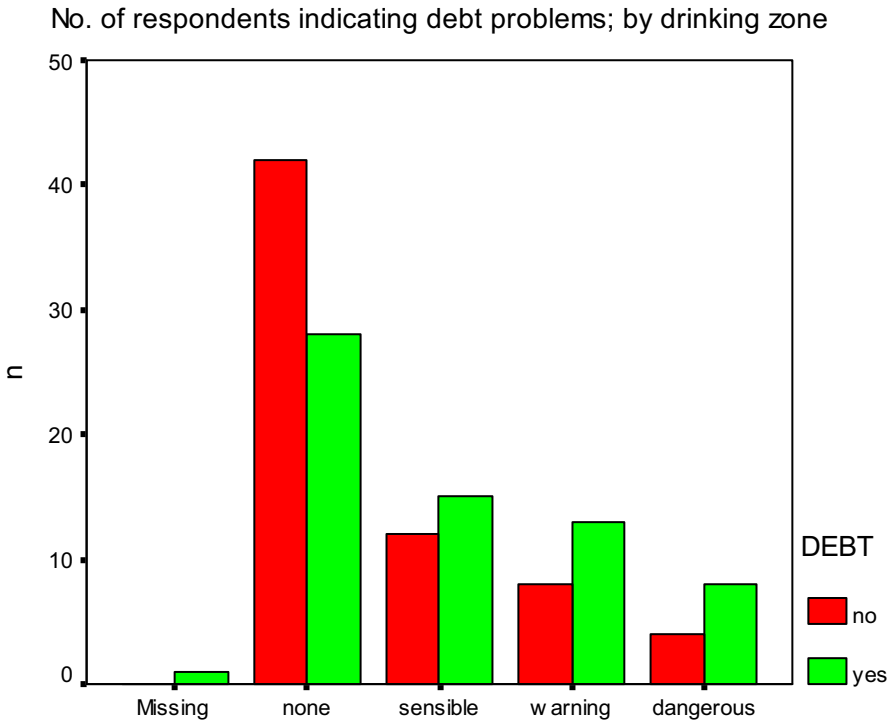
23 of the 33 who reported problems with their employment situation were among the 71 individuals who indicated that they had been unemployed for more than a year. Of the 31 respondents who indicated how much help they needed with this problem, 16 said they needed *some* help and 15 said they need a *high* amount of help.

Debt

Sixty-five (50%) respondents indicated that they had debt problems. Of these, 8 indicated that they were already getting help from services and 39 of the remaining 57 said they would use an appropriate service if it was set up in their area. Twenty-six respondents said that their family or friends helped them with these problems. Of the 61 respondents who indicated how much help they needed with this problem, 19 said they needed *some* help and 25 said they need a *high* amount of help.

A significant[1] relationship with reported alcohol use in the previous week was found such that respondents who indicated debt problems were under-represented in the 'none' category, and progressively over-represented in the 'sensible', 'warning' and 'dangerous' categories (see chart 15). Those reporting debt problems were also significantly[2] more likely to have reported that they had alcohol *problems*.

Chart 15



[1] Oneway ANOVA F = 5.419, $p = 0.021$
[2] Pearson Chi-Square = 5.256, $p = 0.022$

Legal situation

Ninety-eight responding clients (75%) reported that they had criminal convictions, and 45 (34%) had court cases pending (see table 15). In terms of relationships with other variables, females were significantly[1] less likely than males to have criminal convictions, and those male respondents who had court cases pending (mean = 28 years) were significantly[2] younger than those who did not (mean = 31 years). A significant[3] difference in the average current methadone doses of those with court cases pending (49 mls) and those without (40 mls) was also found. It should be noted that there was no significant correlation between age and current dose.

Table 15
Legal situation; by gender

	criminal convictions		**court cases pending**	
	frequency	percent	frequency	percent
male	81	84%	33	34%
female	17	49%	12	34%
total	98		45	

A relationship with reported alcohol consumption in the last week was also found such that males who had drunk more than the maximum recommended weekly amount of alcohol in the previous week were significantly[4] more likely to have court cases pending than those who had not. Considering both male and females respondents together, those who reported having injected drugs in the previous week were also more likely to have court cases pending[5].

Legal problems

Seventeen (13%) respondents reported that their legal situation was a problem. Six of these indicated that they were already getting help from services and 9 of the remaining 11 indicated they would use an appropriate service if it was set up in their area. Six respondents said that their family or friends helped them with these problems. In terms of how much help they needed with this problem, one respondent indicated a *low* amount of help, five indicated *some* help and 11 said they need a *high* amount of help.

[1] Pearson's Chi-Square = 17.447, $p = 0.000$
[2] Independent samples t test, t = 2.065, $p = 0.042$
[3] Independent samples t test, t = -2.846, $p = 0.005$
[4] Pearson's Chi-Square = 7.470, $p = 0.006$
[5] Fisher's Exact Significance (1-sided) = 0.043

Treatment status

Length of time in treatment

Table 16 shows the length of time (in years) that clients had been in treatment. The length of time in treatment ranged from 1 – 121 months (mean = 27.1), and the modal (most frequently occurring) number of months in treatment was 24. When the relationship between the length of time in treatment and other variables were investigated, a number of significant results were found.

Table 16
Length of time in treatment

	Frequency	Percent	Cumulative Percent
missing	7	5.34	5.34
0-1 years	42	32.06	37.40
1-2 years	33	25.19	62.60
2-3 years	22	16.79	79.39
3-4 years	11	8.40	87.79
4-5 years	7	5.34	93.13
5-6 years	3	2.29	95.42
6 years or over	6	4.58	100.00
Total	**131**	**100**	**-**

The average length of time in treatment of those respondents who reported physical problems (33 months) was significantly[1] longer than those who did not report such problems (23 months). However, those reporting physical problems were also significantly[2] older on average (32.5 years) than those who did not (28.6 years). Further, although there was no significant correlation[3] between amount of alcohol drank in the last week and length of time in treatment, the mean length of time in treatment for those reporting that they had an alcohol *problem* (16 months) was significantly[4] lower than that of those who did not perceive their drinking as problematic (28 months).

In terms of legal situation, the mean length of time in treatment for those clients who reported having legal problems (20 months) was significantly[5] less than those who did not (28 months). Additionally, a positive correlation[6] was found between treatment length and current methadone dose, such that dose increased with length of time in treatment. No significant differences were found in terms of gender or any of the other problem areas.

[1] Independent samples t test, t = -2.399, $p = 0.027$
[2] Independent samples t test, t = -2.399, $p = 0.002$
[3] Pearson's $r = -0.009$, $p = 0.923$
[4] Independent samples t test, t = 3.496, $p = 0.002$
[5] Independent samples t test, t = 2.229, $p = 0.031$
[6] Pearson's $r = 0.195$, $p = 0.032$

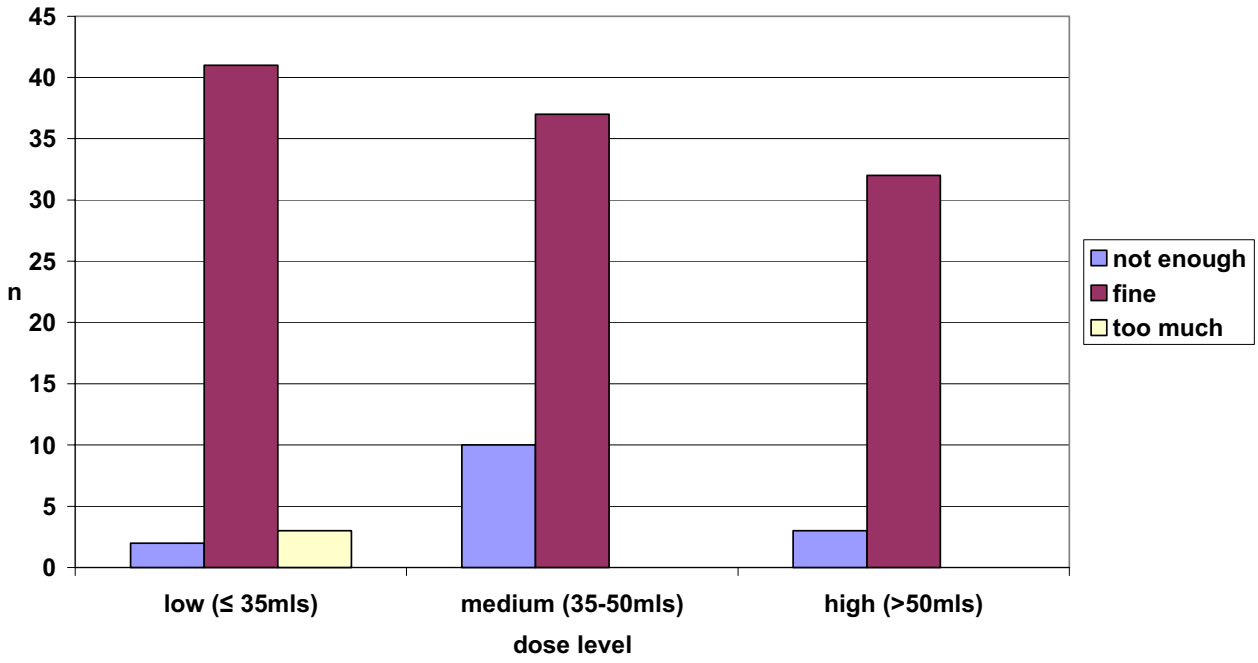
Current daily dose

Respondents were asked to indicate their current daily dose of methadone in millilitres. The doses reported ranged from 6 to 95 mls. The mean dose was 43 mls and the modal dose was 50 mls. Due to a lack of clarity regarding how many and which clients were on maintenance or reduction regimens, no attempts were made to compare characteristics of those above and below the recommended minimum effective maintenance dose of approximately 60mg[1]. On investigation, no statistically significant relationships were found between current daily dose and other variables such as gender, alcohol consumption, or use of illicit drugs in the previous week.

In terms of how they felt about their current dose, 112 (85.5%) respondents felt it was 'fine', 15 (11.5%) that it was 'not enough', and three (2.3%) that it was 'too much'. When this was considered against current dose, it was found that those who felt their dose was not enough were on average receiving higher doses (mean = 48mls) than those who felt 'fine' (mean = 42mls), who were in turn on average receiving higher doses than those who felt their dose was too much (mean = 27mls). Chart 16 shows clients' dose levels and reported satisfaction.

Chart 16

Satisfaction with current dose; by dose level*



missing = 3
*based on percentile groups

[1] DOH (1999); EIU (2002e)

Supervision status

A majority of 119 (91%) respondents' methadone consumption was supervised, the remaining 22 (9%) being unsupervised. Clients were asked how they felt about the supervision arrangements. As shown in table 17, whereas the unsupervised clients were either ambivalent or happy with their arrangements, 24 (19%) and 19 (15%) supervised clients respectively were very unhappy or unhappy with their supervision arrangements.

Table 17
Feelings about supervision arrangements; by supervision status

		Feelings about arrangements					**Total**
		very unhappy	unhappy	don't care	happy	very happy	
Supervised?	no	0	0	2	5	3	**10**
	yes	19	24	23	45	7	**118**
Total		**19**	**24**	**25**	**50**	**10**	**128**

Missing=3

Ten (7.6%) respondents reported that they had not discussed their dose with their GP or Counsellor in the last 3 months, and 13 (10%) reported that they did not always feel able to negotiate their dose. These included 2 of the 3 clients who felt their dose was too much, and 4 of the 15 clients who felt it was not enough.

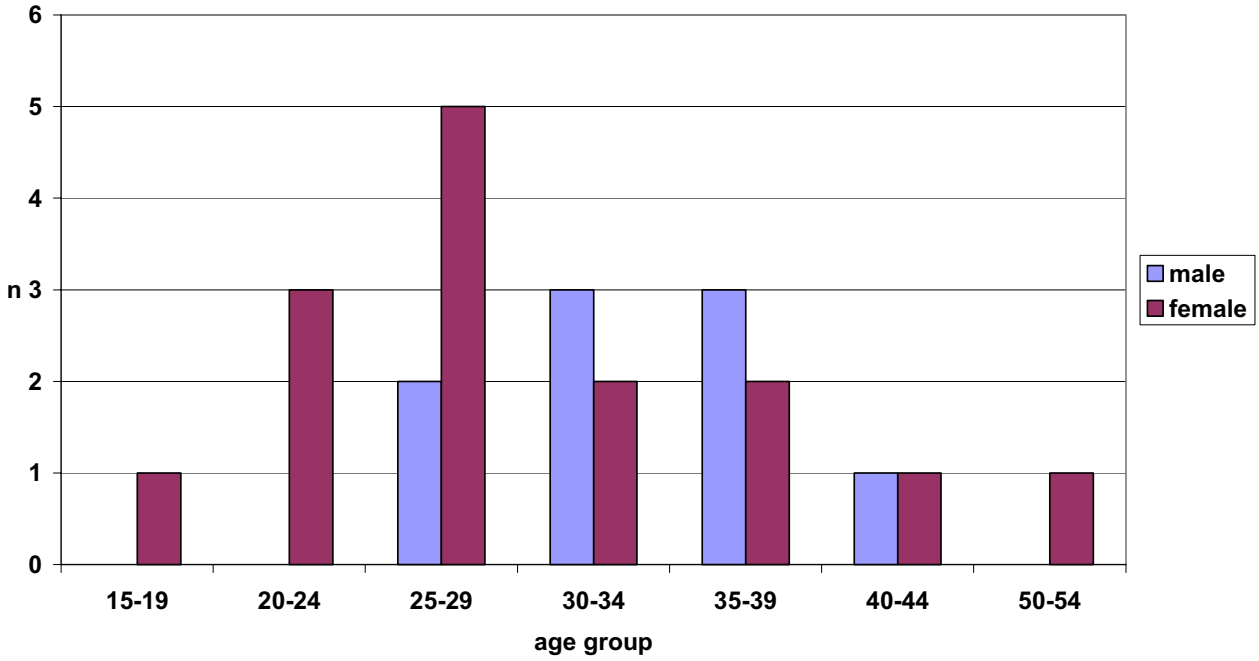
Parents of dependent children

Following presentation of the initial findings of this study to the ADAT, it was requested that a separate analysis of the results be conducted with regard to respondents with dependent children.

As indicated in the 'Living arrangements' section, 24 respondents indicated that they lived with dependent children. Fifteen of these respondents were female and nine were male, which represents 43% and 9% of the total sample respectively. The females ranged in age from 18 – 50, and the males from 27 – 41. Chart 17 shows their age group distribution.

Chart 17

Age distribution of respondents with dependent children; by gender



The responses of clients living with dependent children were compared with the responses of those who indicated that they did not (see appendix for results tables). Significantly more respondents living with dependent children indicated accommodation problems (58.3% vs. 28%) and living arrangement problems (45.8% vs. 14%) than those who did not live with dependent children.

In addition, significantly fewer respondents living with dependent children indicated that they had criminal convictions (54.2% vs. 79.4%). Respondents living with dependent children also reported spending significantly less time using council or private leisure facilities each week (average 0.08 hours vs. 0.67 hours), but were no more likely to indicate that access to leisure was a particular problem for them. No other statistically significant differences were found in the responses of those living with dependent children when compared with those not living with dependent children.

Summary of results

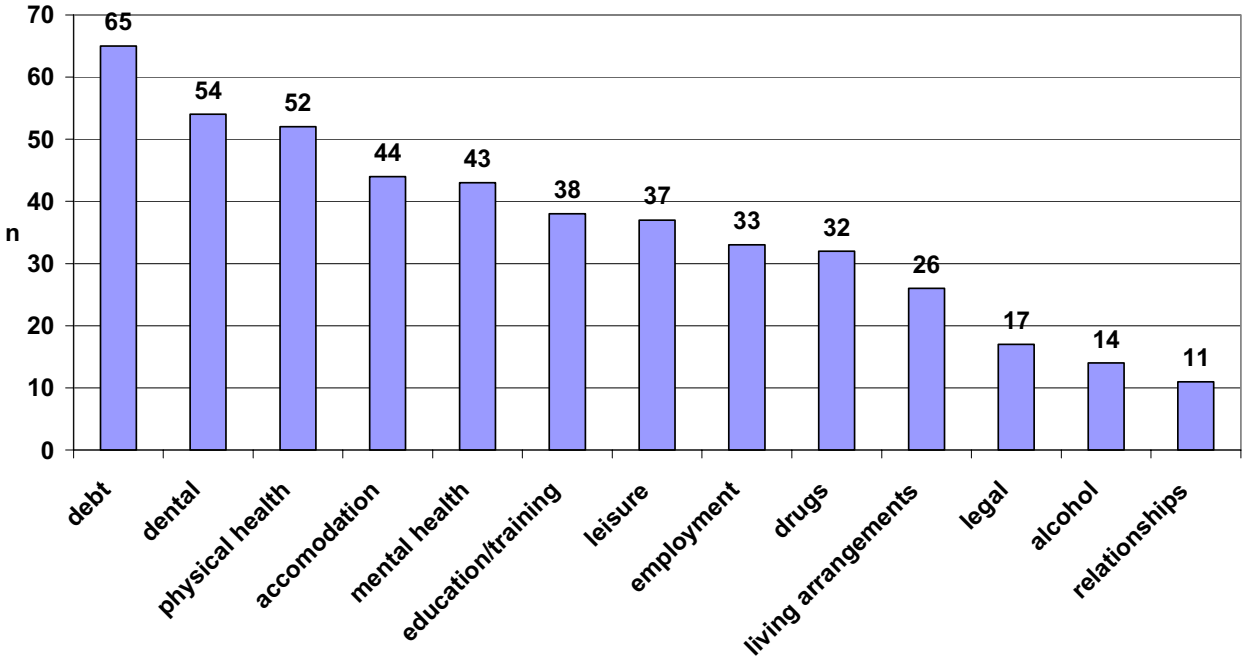
The majority of clients (59%) indicated that they had current problems in three or more of the problem areas considered in the study. The most commonly cited problem areas were debt, dental health, physical health, accommodation, and mental health (table 18/chart 18). When the amounts of help needed with each problem on a scale of 0 to 3[1] were aggregated, it was found that the problems with which clients indicated they needed the *most* help were debt, accommodation, dental health, mental health and physical health (chart 19).

Table 18
Number & percentage of respondents indicating problem areas

Problem area	N	%
Debt	65	50%
Dental health	54	41%
Physical health	52	40%
Accommodation	45	35%
Mental health	43	33%
Education/training	38	29%
Leisure	37	28%
Employment	33	25%
Drugs	32	24%
Living arrangements	26	20%
Legal	17	13%
Alcohol	14	11%
Relationships	11	8%

Chart 18

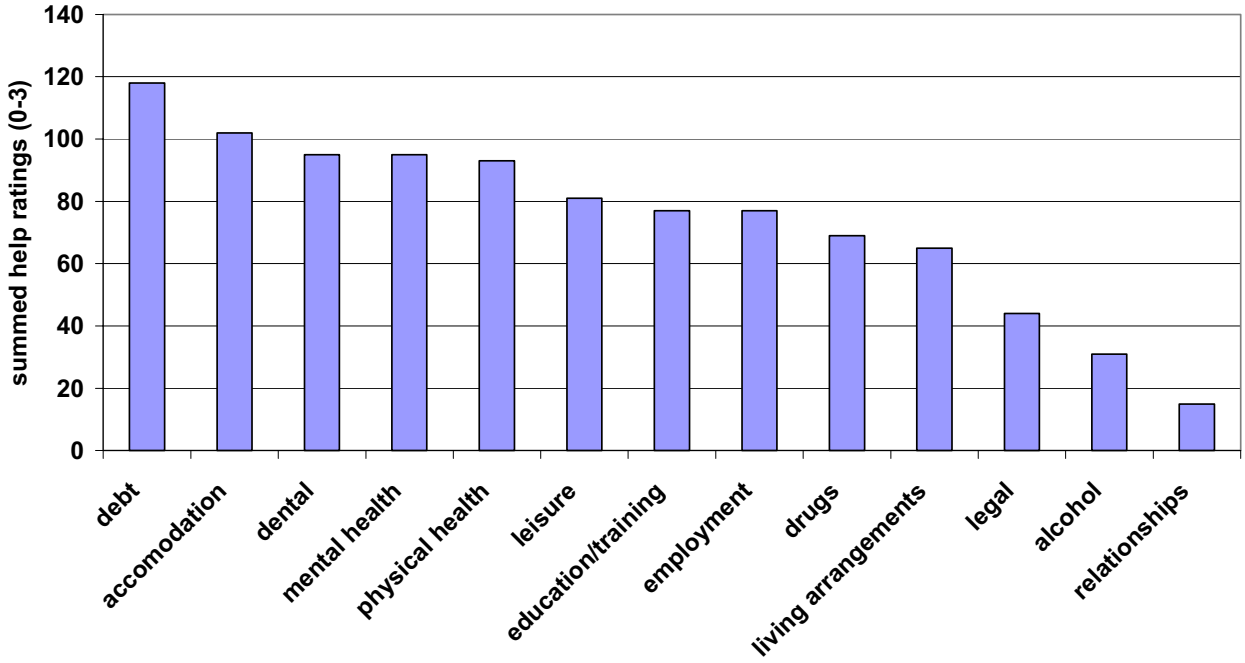
No. of respondents indicating problem; by problem type



[1] 0 = no help, 1 = low amount of help, 2 = some help, 3 = high amount of help

Chart 19

Total amount of help needed; by problem type



Many clients who indicated problems were not currently receiving help from services, particularly in the areas of debt, education/training, leisure and dental health (chart 20). Where clients were not currently receiving help from services there was overall a high degree of reported willingness to use appropriate services if they were established locally – particularly in relation to living arrangements and drug problems (chart 21).

Chart 20

No. of respondents not currently being helped by services; by problem type

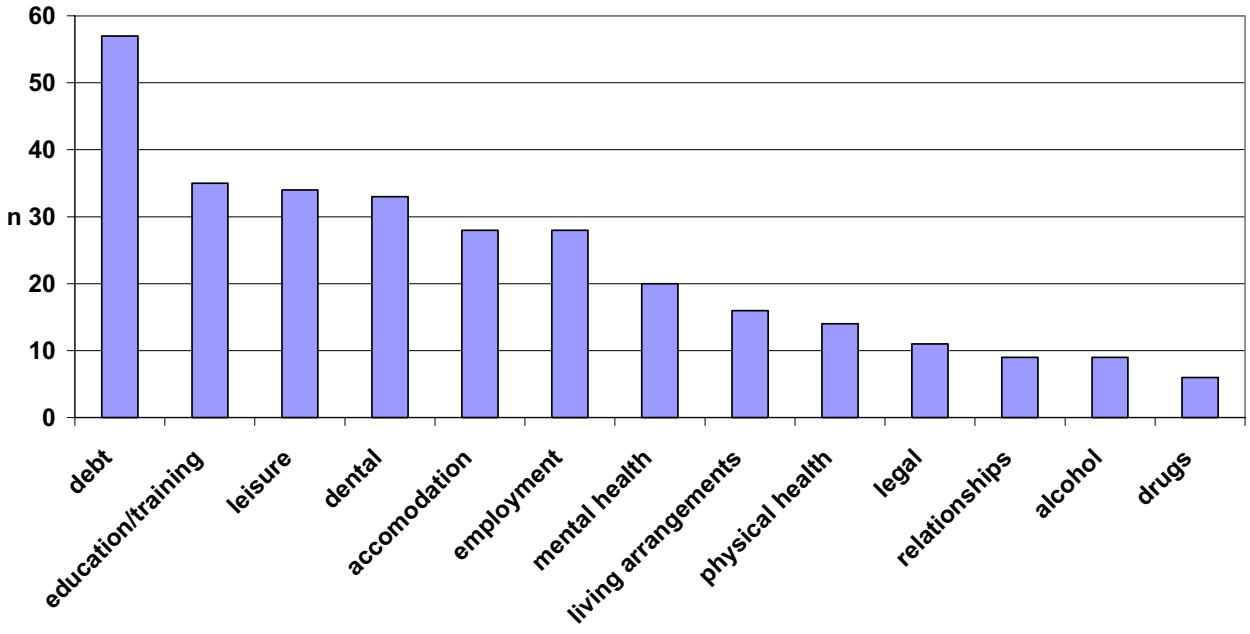
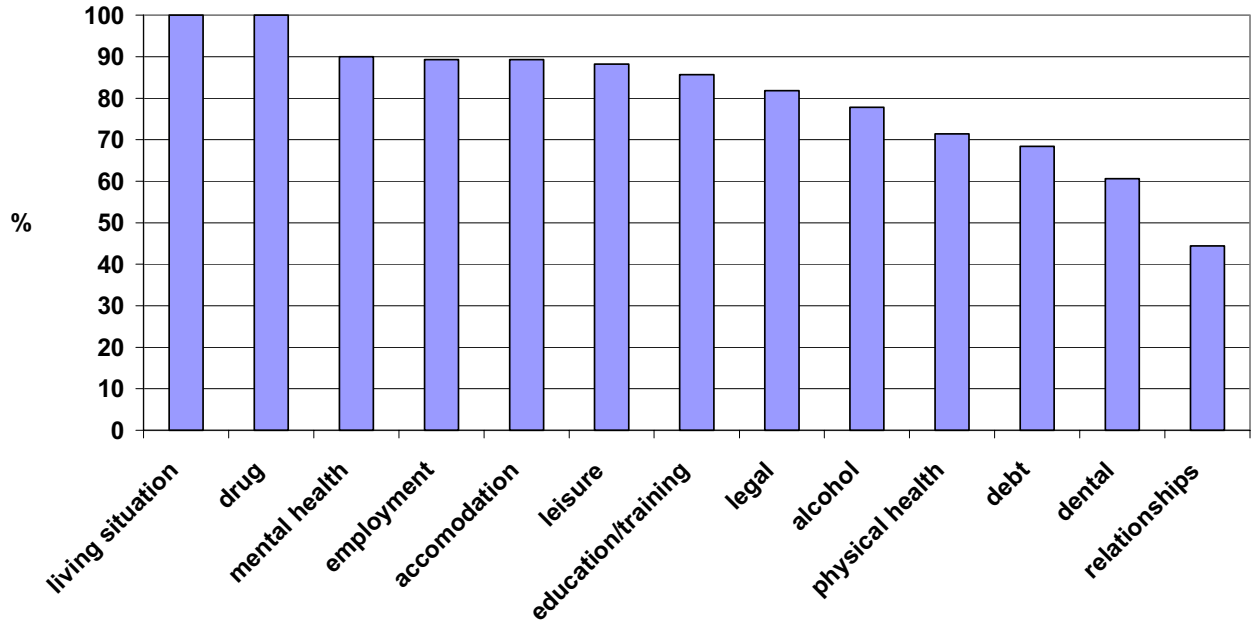


Chart 21

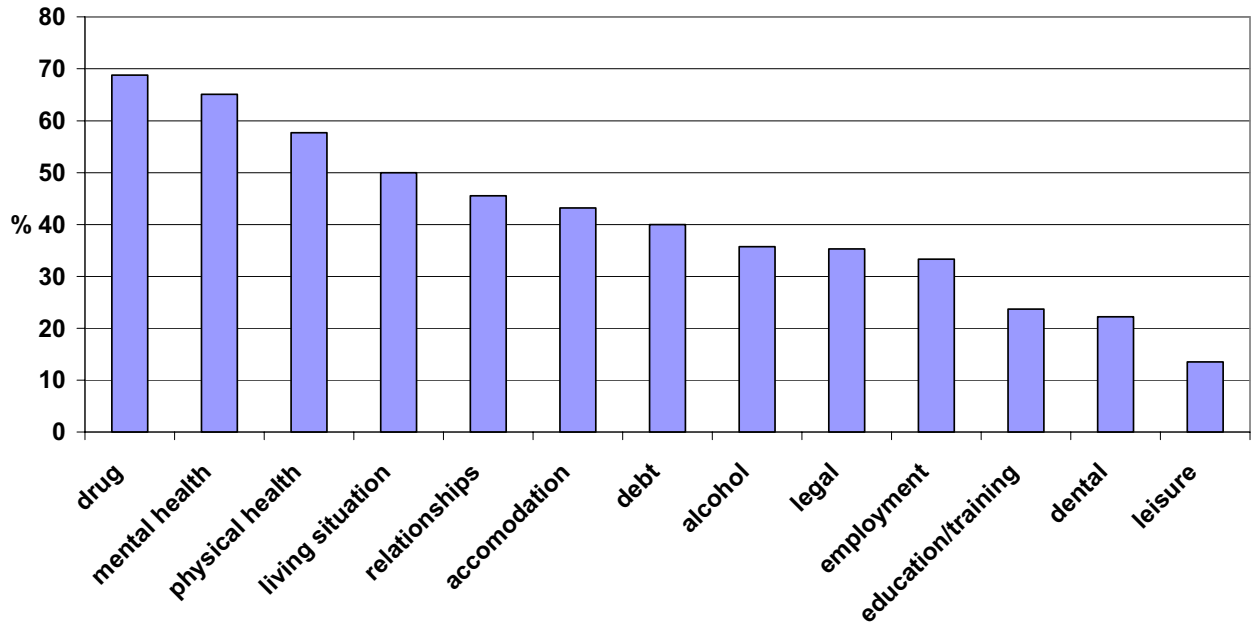
Percentage of respondents not currently receiving help from services who would use local service; by problem type



The degree of social support provided to respondents by family and friends varied widely depending on the type of problem. This was highest in relation to drug, mental health and physical health problems (chart 22).

Chart 22

Percentage of respondents receiving help from family/friends; by problem type



Discussion

Several issues can be identified as particularly problematic from the perspective of longer-term methadone clients.

Half of all respondents indicated that they had a debt problem. Due to the likelihood that many people in Lanarkshire, as elsewhere[1], probably rely on credit and hire purchase on a regular basis, it is acknowledged with hindsight that it may have been more informative to include further questions in the survey in relation to the nature of debt and debt problems. For instance, in addition to the potential for problems directly linked to the use of illicit drugs, recovering drug users can also have comparatively poor access to credit resulting in the incurring of debt through having to borrow money at higher rates. Nevertheless, given that debt was also the problem for which most respondents indicated that they needed the greatest amount of help, it is clear that it is perceived as a significant problem.

Debt problems were also found to be linked to potentially harmful levels of alcohol consumption and perceived alcohol problems. However, whether or not the link between alcohol and debt problems was perceived by clients, and the nature of the link between the two in causal terms, remains unclear. Indeed this is an area in which there appears to be a lack of readily available statistics or robust research[2].

Given the apparent magnitude of debt problems and the fact that less than a quarter as many methadone clients were in part or full-time employment as compared to Lanarkshire residents in general, it is noteworthy that employment was not perceived as more of a major issue. This may be related to a lack of readiness for entering employment or may reflect a lack of focus on employment by treatment services. Since the termination of the Program for Independent Living Lanarkshire in 2002 there have, until recently, been no Lanarkshire-wide services designed specifically to support stable alcohol/drug users to make positive, longer-term lifestyle choices and address the potential barriers to training and employment.

Due to the relatively high percentage of methadone clients receiving income support (50%) it is also a possibility that the so-called "benefits trap" may be a factor. This occurs where people on income support who want to go back to work feel that the job they are considering is not sufficiently well paid and they may in fact be worse off if they give up their benefits. It is also possible that clients receiving daily supervision of their methadone consumption may perceive or have experienced problems in relation to attending work or training programmes. In any case, considerable interest in using an appropriate local service relating to debt problems was expressed by those not currently receiving help from services.

Accommodation is another problematic issue in which methadone clients appear to be generally disadvantaged compared to other Lanarkshire residents. Once again there seemed to be a high level of motivation to use an appropriate local service and almost two thirds of clients reporting problems said they were not currently receiving help. While it is obvious that homeless or supported clients should be a priority in this area, it should be noted that around half of the survey respondents who were privately renting and around a third of those renting form the Council indicated that accommodation was a problem for them.

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[1] For example, the average UK household spends £135.20 a year on paying off loans to clear other debts (National Statistics, 2003). In addition, a recent survey of 1000 people from across the UK reported that people living in Scotland were most likely to suffer because of money worries – only 28% said that finances had never affected other areas of their lives. (Prudential, 2003).

[2] While it is possible, for instance, to determine from national statistics that average weekly expenditure on alcohol varies proportionately with income in terms of decile groups (National Statistics, 2003), this does not reveal anything about average weekly expenditure as a proportion of income or the relationship with debt.
The Prudential survey also found that 5% of respondents reported increasing their consumption of alcohol as a result of money worries (Prudential, 2003).

The three aspects of health enquired about in the study also emerged as relatively highly problematic issues for many respondents. Dental health in particular was an area in which most clients with problems were not currently receiving any help (61% of those indicating dental problems). It may be the case that the prominence of dental problems is a reflection of the poor level of dental health in the general population. For instance in the LHLS (1996) it was found that 1 in 5 adults in Lanarkshire had none of their natural teeth, and that only 43% of those who rented their accommodation from the public sector had visited a dentist within the last year. Nevertheless it is likely that dental problems and indeed some of the barriers to dental treatment reported in the LHLS, such as expense and nervousness, would be exacerbated in the case of methadone clients.

Given the common co-occurrence of substance use and mental health problems[1], it was not entirely surprising that a third of respondents indicated problems in this area. The prevalence of anxiety, and depression in particular, support the findings of previous studies of methadone clients[2], as does the association with reported use of benzodiazepines[3]. While in-depth discussion of the nature and causal direction of the relationship between mental health problems and substance use is beyond the scope of this study, it is clear that the national and local prioritisation of dual diagnosis issues is well justified.

It was noted above that addressing the health-related consequences of problem drug use is a primary outcome of treatment programmes. However as per the NTORS findings it is apparent that ongoing concerns caused by physical problems, which can persist beyond changes in substance use behaviour, remain a significant issue for many longer-term methadone clients. The main problem identified was asthma which again is probably a reflection of the extent of this health problem in the general population. However the incidence of blood-borne virus (BBV) related problems, considered in combination with the other health problems reported, serves to emphasise the need for a more holistic inter-agency approach focussing on wider aspects of health and wellbeing.

[1] See e.g. Myrick and Brady (2003)
[2] E.g. Strain, Brooner & Bigelow (1991); Limbeek et al. (1992)
[3] Darke, Shane, Swift, and Wendy (1994)

Conclusion

Recovering drug users face a variety of problems in their lives, and their perceptions of these problems are not necessarily the same as those of other groups such as policy makers and service providers. As part of a process of needs assessment and the development of person-centred planning, it is important to assess the problems of recovering drug users as they perceive them. This information can then be considered alongside various other service demands and compared with the current supply and accessibility of services through service and process mapping in order to assess areas of unmet need.

Action in progress

Since this survey was conducted (Autumn 2002) considerable work has been initiated or progressed in several of the problem areas investigated. These are briefly outlined below.

Employment

The relative lack of emphasis on employment as a problem, in spite of significant debt problems and high unemployment rates among clients, was identified as an issue in this study.

The Progress2Work scheme was launched in Lanarkshire in February 2003. This Jobcentre Plus initiative, managed by South Lanarkshire Council, has been funded for 18 months and aims to assist 450 former drug users to engage in mainstream employment provision and to secure and sustain jobs.

A further three related services have secured an award from the *New Opportunities Fund* (NOF) in recent months*.

- The Positive Employer Attitudes and Real Lives (PEARL) project aims to engage and intensively support 120 employers in order to raise awareness and understanding of the positive aspects of employing former problem substance users. The project will also provide employment for approximately 30 former problem substance users, and will combine with Progress2Work to offer opportunity, flexibility and choice for both employers and recovering drug users.

- The Workplace Initiative Employment Support, aims to help over 100 unemployed people from Blantyre and North Hamilton with drug misuse problems who require intensive support to begin the process of accessing employment.

- South Lanarkshire Volunteering Enterprise (SoLVE) will work with specialist substance misuse teams to provide a volunteer placement service for individuals with problem drug use issues. A volunteering mentoring service will also be set up and the scheme will provide specialist support allowing clients access to tailored volunteering opportunities.

Physical health

Over the last 18 months or so substantial progress has been made in relation to addressing BBV-related problems among at-risk populations in Lanarkshire, which include methadone clients. The appointment of a BBV risk reduction nurse has resulted in 310 individuals completing an accelerated Hepatitis B vaccination programme. The opportunity to discuss the potential risks of other BBVs is also taken with all individuals engaging with the programme (a total of 409 so far).

A further outcome of the risk reduction strategy is the training of all LDS and a proportion of CAT nurses in BBV testing, and pre and post-test counselling. A patient group directive which will allow all registered nurses working with problem substance users to administer the Hepatitis B vaccination has also been established, and several nurses working within LDS are already administering booster jabs.

* source: Lanarkshire ADAT Bulletin, Issue No. 5, Summer 2003

Accomodation

Accommodation is another problematic area for methadone clients in which progress has subsequently been initiated.

- In North Lanarkshire Council four housing support workers, based within the housing department of social work, have been engaged to work specifically with people experiencing drug and alcohol-related problems. The main remit of the posts involve a focus on homelessness, and help and support for people in tenancies to maintain their tenancies. A further aspect of the posts involves getting people who have been in residential rehabilitation back into accommodation.

- South Lanarkshire Council have recently secured an award from the *New Opportunities Fund* (NOF) in relation to this problem area. The Negotiated Entry to a Secure Tenancy (NEST) service will provide 20 secure tenancies to homeless people with stabilised drug misuse problems in South Lanarkshire. Clients will be offered tenancies for an initial six month period along with a programme of care that will address substance misuse to enable them to maintain longer term tenancies and sustain their social inclusion[*].

- As an interim step towards longer-term service development, additional resources have been allocated by the ADAT to the Primary Care Health and Homeless Team.

Mental Health

The Treatment & Care sub-group of the Alcohol & Drug Action Team has prioritised the development of a dual diagnosis service in Lanarkshire. It is envisaged that this service will involve the positioning of two specialist psychiatric nurses within mainstream psychiatric nursing services that carry a small caseload of particularly complex patients, conduct an assessment of the needs of this care group, provide support and consultation to colleagues, and liaise with addiction and other local services.

It is anticipated that this development will:

- Raise awareness of mental health issues and therapeutic responses
- Raise awareness of alcohol & drug related issues & therapeutic responses
- Raise awareness of the relationship between substance misuse and mental health problems
- Challenge negative attitudes and prejudices around both mental health problems and substance misuse
- Increase staff confidence and reduce fear and anxiety in relation to working with people with complex needs
- Increasing shared training opportunities for assessment and referral
- Increase knowledge of other relevant services and referral criteria
- Increase knowledge and awareness of cultural and gender issues
- Ensure that user views are accessed and acted upon
- Reduce waiting times to access CAT (proposed transfer of clients to Community Mental Health Teams)
- Avoid clients being shunted from one service to another and where appropriate are incorporated into Care Programme Approach.

[*] source: Lanarkshire ADAT Bulletin, Issue No. 5, Summer 2003

Additional Progress

- A new day care provision run by Phoenix is being set up in South Lanarkshire. This service will provide person-centred plans to help stabilised clients develop life skills and sustain improvements.

- Six new rehabilitation posts have been established within North Lanarkshire Council. These posts have been designed to help meet the individual needs of methadone clients and link them into appropriate services.

- A73, a rural outreach service, has been established in Clydesdale. Using an action research approach this service will address negative consequences of drug-related harm and encourage drug users to make contact with services.

Priority areas

Various other problem areas identified by methadone clients remain as priorities for consideration via service and process mapping.

Debt management and welfare advice

Both North and South Lanarkshire Council Social Work Substance Misuse Teams provide assistance, support, and advice to recovering drug users in relation to welfare issues. However, the extent of expertise in the specific area of debt management, and the accessibility of this service to methadone clients is unclear. As part of the ADAT strategy it should be ensured that issues relating to debt and financial problems are incorporated by all agencies involved in the treatment/care of problem substance users as part of single-shared assessment, care management and review procedures.

Accommodation

As noted above, steps have been taken in recent months throughout Lanarkshire to address accommodation problems faced by recovering drug users. It should be ensured that the needs of those living in rented accommodation are also considered, as these groups appear to be suffering considerable problems in this respect. Issues relating to accommodation problems of all methadone clients, regardless of their current accommodation status, should therefore be explored by agencies involved in the treatment/care of problem substance users as part of single-shared assessment, care management and review procedures.

Alcohol and illicit drug problems

As noted in the recent NTORS five year follow-up report alcohol use is a serious issue for drug treatment clients as dually dependent clients can have higher rates of criminal involvement[1] and more health problems than problem drug users without drinking problems (Gossop et al., 2001). In correspondence with NTORS findings, the current study found that one quarter of long-term methadone clients were drinking above recommended sensible limits. A strong link was also found between alcohol and debt problems. In addition clients who **did not** perceive they had alcohol problems had, on average, been in treatment for longer periods than those who **did** perceive problems, in spite of no significant differences between the two groups in the amount of alcohol used in the previous week. This would suggest that longer-term methadone clients may be less likely to identify and seek help regarding alcohol-related problems.

In terms of illicit drug use, it is possible that benzodiazepine use in particular should be targeted for two reasons. Firstly, due to the additive effect on central nervous system depression opiate dependent individuals who misuse benzodiazepines and alcohol[2] run an increased risk of overdose. Secondly, the results of this study support previous findings regarding the association between benzodiazepine use and depression and anxiety (Darke et al., 1994).

These issues serve to highlight the importance of ensuring that alcohol and illicit drug problems are systematically identified, addressed and reviewed *throughout* the process of treatment and support by agencies involved with problem substance users.

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[1] Indeed, males in the current study who had drunk more than the maximum recommended weekly amount of alcohol in the previous week were significantly more likely to have court cases pending than those who had not.

[2] Benzodiazepine users were also more likely to have drunk more alcohol in the previous week than non-benzodiazepine users.

Dental health

While progress towards improving dental health is being made in preventative terms through the prescribing of sugar-free methadone, it remains that significant dental problems and barriers to dental treatment are perceived by a high proportion of methadone clients. Taken in combination with the findings relating to other physical health problems, it is clear that (as per national treatment guidelines) regular physical examinations of methadone clients should be conducted to determine the presence of any complications of drug misuse including asthma, blood-borne viruses, deep vein thrombosis, dental disease, and infections (DOH, 1999).

Limitations

Several factors may have served to limit the scope and accuracy of this study. Perhaps most importantly, for a variety of reasons it turned out to be impossible to adopt the service-user involvement approach to the survey methodology that was initially intended. It was envisaged that this approach would serve the dual purpose of promoting service user involvement and gathering more candid views on current service provision users than could otherwise be obtained by asking staff to ask clients for their views or using self-completion questionnaires.

In the absence of this methodology, and in spite of guarantees of anonymity in the case of self-completion, it is possible that clients may have been influenced by real or perceived expectations regarding their responses - particularly in relation to reporting sensitive or adverse issues such as alcohol and drug use and mental health problems. This could for example have served to mask positive outcomes over treatment length – underreporting of drug and alcohol use may have been more likely among the groups who had been in treatment for shorter periods. For similar reasons, individuals with greater treatment experience may be more open about sensitive issues such as health problems.

A further two potential limitations may also have arose from this methodological issue. Firstly, unlike the service-user groups who had undergone training in survey methodology, the clinic staff who distributed the survey may not have explained the issues of consent and anonymity as fully as would have been desired. In addition, no measures were in place to measure refusals or non-returns. A further limitation relates to the variation in effort among clinic staff in terms of carrying out the survey. This has led to a skewing of the sample such that analysis at smaller geographical area level (such as LHCC) has not been possible. On the positive side, some valuable lessons have been learned in relation to potential difficulties involved in partnership working and service-user involvement.

Finally, it is recognised that there may not have been sufficient scope in the questionnaire for clients to express problems that they were not specifically asked about. While a comments section was included for this purpose it was not used to any considerable degree.

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Appendix – Respondents living with dependent children

Table 19
Comparison of respondents living with dependent children with other respondents on selected variables

Variable	Dependent children %	No dependent children %	Chi-Square value	Significance
Accommodation problem	58.3	28	8.066	**.005**
Living arrangements problem	45.8	14	Fisher's Exact Test	**.001**
Relationships problem	12.5	7.5	Fisher's Exact Test	.422
Education problem	37.5	27.1	1.029	.310
Leisure problem	41.7	25.2	2.612	.106
Physical health problem	50.0	37.4	1.304	.254
Dental health problem	41.7	41.1	.002	.961
Alcohol	4.2	12.1	Fisher's Exact Test	.464
Drug problem	16.7	26.2	.959	.328
Drug user	41.7	50.5	.608	.436
Cannabis user	12.5	30.8	3.309	.069
Benzo user	8.3	11.2	Fisher's Exact Test	1.000
Injected	12.5	5.6	Fisher's Exact Test	.365
Shared equipment	8.3	9.3	Fisher's Exact Test	1.000
Mental health problem	29.2	33.6	.178	.673
Employment problem	20.8	26.2	.296	.586
Debt problem	33.3	53.3	3.117	.077
Convictions	54.2	79.4	6.644	**.010**
Cases pending	33.3	34.6	.013	.908
Legal problem	20.8	11.2	Fisher's Exact Test	.309

Table 20
Comparison of respondents living with dependent children with other respondents on selected variables

Variable	Dependent children mean	No dependent children mean	t-test statistic	Significance
Leisure hours	0.08	0.67	3.060	**.003**
Alcohol units last week	4.3	20.79	1.821	.071
Treatment length	33.71	25.51	-1.667	.098
Current dose	42.29	43.39	0.264	.792

Table 21

Descriptions of problems with accommodation/living arrangements by respondents living with dependent children

"Cannot manage stairs, unable to do household activities, family do not help."

"High-rise flat, 2 small children."

"House is too big."

"Need help with children."

"Not enough rooms."

"Overcrowding - 3 children unable to get out and play."

"Overcrowding."

"Problems with neighbours."

"Too much temptation as the area is overrun with drugs."

"Too small as we are taking in another relative."

"Very overcrowded."